MACRA and the CMS Quality Payment Program (QPP)

Howard Pitluk, MD, MPH, FACS
Vice President, Medical Affairs & Chief Medical Officer
Health Services Advisory Group (HSAG)

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MACRA = Medicare Access and Children's Health Insurance Program [CHIP] Reauthorization Act of 2015
CMS = Centers for Medicare & Medicaid Services

Disclosure

I have nothing to report nor are there any real or perceived conflicts of interest, implied or expressed, in the following presentation.

Howard Pitluk, MD, MPH, FACS

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HSAG: Your Partner in Healthcare Quality

- HSAG is the Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Arizona, California, Florida, Ohio, and the U.S. Virgin Islands.
- HSAG is and has been committed to improving healthcare quality for more than 35 years.
- QIN-QIOs in every state/territory are united in a network under the Centers for Medicare & Medicaid Services (CMS).
- The Medicare QIO Program is the largest federal program dedicated to improving healthcare quality at the community level.

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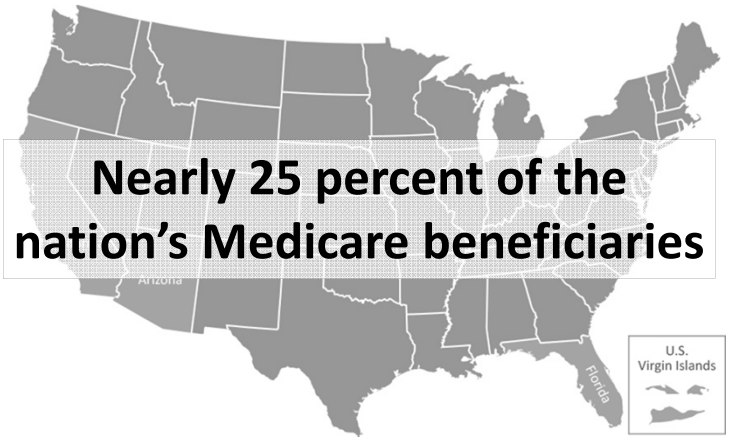
HSAG's QIN-QIO Territory



HSAG is the Medicare QIN-QIO for Arizona, California, Florida, Ohio, and the U.S. Virgin Islands.

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What Is MACRA?

MACRA stands for the Medicare Access & CHIP* Reauthorization Act of 2015, bipartisan legislation signed into law on April 16, 2015.

* Children's Health Insurance Program

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What Does MACRA Do?

- **Repeals** the Sustainable Growth Rate (SGR) Formula.
- **Changes the way that Medicare pays clinicians** and establishes a new framework to reward clinicians for value over volume.
- **Streamlines** multiple quality reporting programs into one new system: MIPS.
- **Provides** bonus payments for participation in eligible APMs.

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What Does Value-Based Payment Mean to CMS?

- Transforming Medicare from a passive payer to an active purchaser of higher quality more efficient healthcare
- Value = Quality/Cost *or* Health Outcomes Achieved/Dollars Spent
- Tools and initiatives for promoting better quality, while avoiding unnecessary costs
  - Tools: Measurement, payment incentives, public reporting, conditions of participation, coverage policy, and regulatory change
  - Initiatives: Pay for reporting, pay for performance, gain sharing, competitive bidding, bundled payment, coverage decisions, and direct provider support (i.e., electronic health record [EHR] incentives, etc.)
- Five principles:
  - Define the end goal, not just the process for achieving it.
  - All providers' incentives must be aligned (includes hospitals and physicians).
  - The right measures must be developed and implemented in rapid cycle.
  - CMS must actively support quality improvement.
  - The clinical community and patients must be actively engaged.

Source: VanLare JM, Conway PH. Value-Based Purchasing – National Programs to Move from Volume to Value. NEJM July 26, 2012

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The Quality Payment Program (QPP)

Clinicians have two tracks from which to choose:

MIPS

The Merit-based Incentive Payment System (MIPS)

If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

OR

Advanced APMs

Advanced Alternative Payment Models (APMs)

If you decide to participate in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

8 Source: The Centers for Medicare & Medicaid Services

Part 1: MIPS Basics

What Do I Need To Know?

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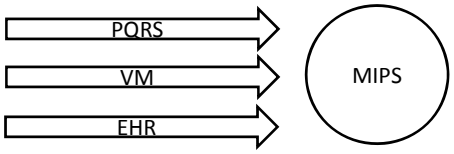
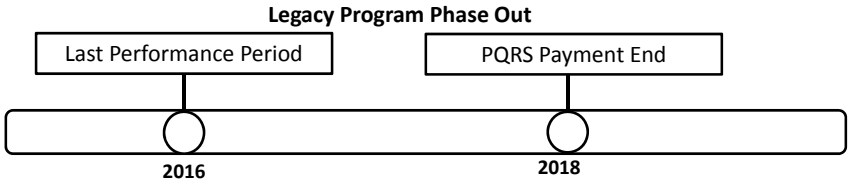
What Is the MIPS?

- Combines legacy programs into a single, improved reporting program





Source: The Centers for Medicare & Medicaid Services

PQRS = Physician Quality Reporting System
VM = Value-Based Modifier
EHR= Electronic Health Record

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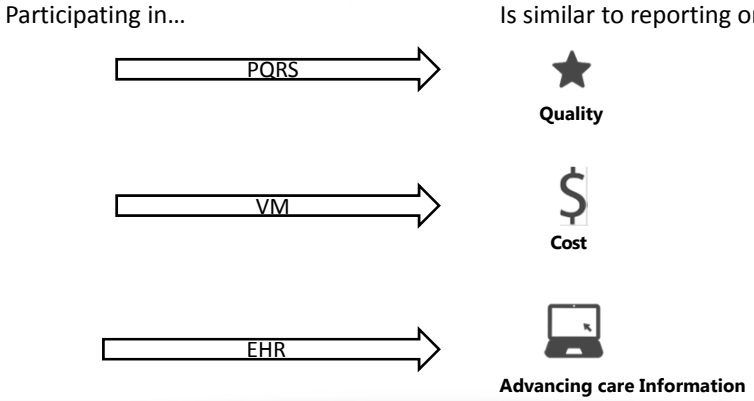
MIPS Visualization

A visualization of how legacy programs streamline into the MIPS performance categories:



11 Source: The Centers for Medicare & Medicaid Services

What Will Determine My MIPS Score?

The MIPS composite performance **score** will factor in **four weighted categories**:

11 Source: The Centers for Medicare & Medicaid Services

MIPS for First-Time Reporters

You Have Asked: *"What if I do not have any previous reporting experience?"*

CMS has provided options that may reduce participation burden to first time reporters by:

- Adjusting the low-volume threshold to exclude more individual clinicians and groups
- Allowing clinicians to pick their pace of participation for Transition Year 2017 by lowering the performance threshold to avoid a negative adjustment

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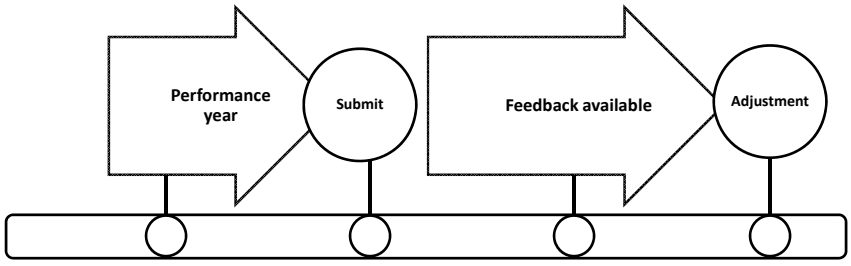
When Does MIPS Officially Begin?



2017
Performance Year

- Performance period opens January 1, 2017
- Closes December 31, 2017
- Clinicians care for patients and record data during the year.

March 31, 2018
Data Submission

- Deadline for submitting data is March 31, 2018.
- Clinicians are encouraged to submit data early.

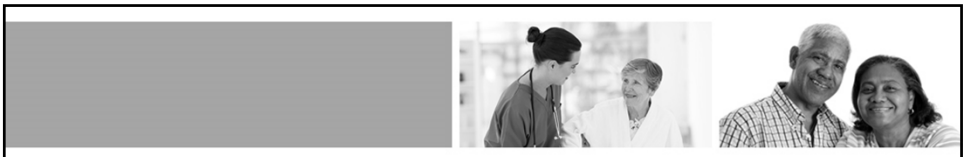
Feedback

- CMS provides performance feedback after data is submitted.
- Clinicians will receive feedback before the start of the payment year.

January 1, 2019
Payment Adjustment

- MIPS payment adjustments are prospectively applied to each claim beginning on January 1, 2019.

14 Source: The Centers for Medicare & Medicaid Services



MIPS Eligibility

What Do I Need to Know?

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Eligible Clinicians

Clinicians billing more than $30,000 a year in Medicare Part B allowed charges **OR** providing care for more than 100 Medicare patients a year.

BILLING ≥$30,000 OR **≥100**

These clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetists

16 Source: The Centers for Medicare & Medicaid Services

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Determine Your Eligibility

How do I do this?
https://qpp.cms.gov/participation-lookup

- Calculate your annual patient count and billing amount for the 2017 transition year.
  - Review your claims for service provided between September 1, 2015 and August 31, 2016, and where CMS processed the claim by November 4, 2016.
  - Did you bill more than $30,000 OR provide care for more than 100 Medicare patients a year?
    - Yes: You are eligible.
    - No: You are exempt.

17 Source: The Centers for Medicare & Medicaid Services

Who Is Exempt From MIPS?

Clinicians who are:

Newly-enrolled in Medicare

- Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

Below the low-volume threshold

- Medicare Part B allowed charges less than or equal to $30,000 a year
  AND
- See 100 or fewer Medicare Part B patients a year

Advanced APM

Significantly participating in Advanced APMs

- Receive 25% of your Medicare payments
  OR
- See 20% of your Medicare patients through an Advanced APM

18 Source: The Centers for Medicare & Medicaid Services

If You Are Exempt

- You may choose to voluntarily submit quality data to CMS to prepare for future participation, but you will not qualify for a payment adjustment based on your 2017 performance.
- This will help you hit the ground running when you are eligible for payment adjustments in future years.

19 Source: The Centers for Medicare & Medicaid Services

Eligibility for Clinicians in Specific Facilities

- Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC)
  - Eligible clinicians billing under the RHC or FQHC payment methodologies are not subject to the MIPS payment adjustment.

However…

  - Eligible clinicians in a RHC or FQHC billing under the Physician Fee Schedule (PFS) are required to participate in MIPS and are subject to a payment adjustment.

20 Source: The Centers for Medicare & Medicaid Services

Eligibility for Non-Patient Facing Clinicians

- Non-patient facing clinicians are eligible to participate in MIPS as long as they exceed the low-volume threshold, are not newly enrolled, and are not a Qualifying APM Participant (QP) or Partial QP that elects not to report data to MIPS.
- The non-patient facing MIPS-eligible clinician threshold for individual MIPS-eligible clinicians is ≤ 100 patient facing encounters in a designated period.
- A group is non-patient facing if > 75 percent of National Provider identifiers (NPIs) billing under the group's Taxpayer Identification Number (TIN) during a performance period are labeled as non-patient facing.
- There are more flexible reporting requirements for non-patient facing clinicians.

21 Source: The Centers for Medicare & Medicaid Services HSAG 20

MIPS Participation

What Do I Need to Know?

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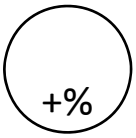
Pick Your Pace for Participation for the Transition Year

Participate in an Advanced APM

MIPS

Test Pace	Partial Year	Full Year
		
• Some practices may choose to participate in an Advanced Alternative Payment Model in 2017	**Submit Something**: • Submit some data after January 1, 2017 • Neutral payment adjustment	**Submit a Partial Year**: • Report for 90-day period after January 1, 2017 • Neutral or positive payment adjustment	**Submit a Full Year**: • Fully participate starting January 2017 • Positive payment adjustment

Note: Clinicians do not need to tell CMS which option they intend to pursue.

Not participating in the QPP for the Transition Year will result in a negative 4 percent payment adjustment.

23 Source: The Centers for Medicare & Medicaid Services

MIPS: Choosing to Test for 2017

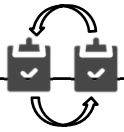
- Submit a minimum of 2017 data to Medicare
- Avoid a downward adjustment
- Gain familiarity with the program

Submit Something

Minimum Amount of Data

1 Quality Measure

OR



1 Improvement Activity

OR

4 or 5 Required Advancing Care Information Measures*

Source: The Centers for Medicare & Medicaid Services

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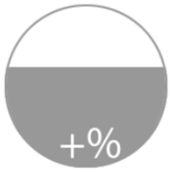
* Depending on certified electronic health record technology (CEHRT) edition

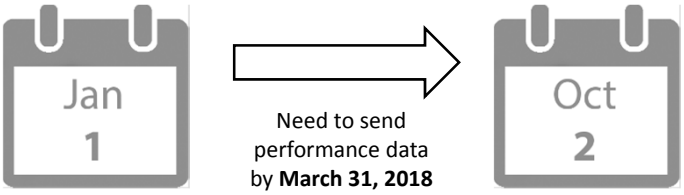
MIPS: Partial Participation for 2017



Submit a Partial Year

- Submit 90 days of 2017 data to Medicare
- May earn a positive payment adjustment

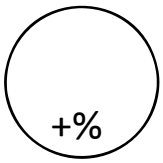
"So what?" — If you are not ready on January 1, you can start anytime between January 1 and October 2.



Need to send performance data by **March 31, 2018**

25 Source: The Centers for Medicare & Medicaid Services

MIPS: Full Participation for 2017



Submit a Full Year

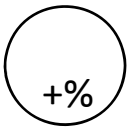
- Submit a full year of 2017 data to Medicare
- May earn a positive payment adjustment
- Best way to earn largest payment adjustment is to submit data on all MIPS performance categories

Key takeaway:
Positive adjustments are based on the performance data on the performance information submitted, not the **amount** of information or **length of time submitted**.

26 Source: The Centers for Medicare & Medicaid Services

Bonus Payments and Reporting Periods

MIPS payment adjustment is based on data submitted.
Clinicians should pick what's best for their practice.



Submit a Full Year

Full year participation
- Is the best way to get the maximum adjustment
- Gives you the most measures to choose from
- Prepares you the most for the future of the program

Submit a Partial Year

Partial participation (report for 90 days)
- You can still achieve the maximum adjustment

27 Source: The Centers for Medicare & Medicaid Services

MIPS Reporting and Submission Methods

What Do I Need to Know?

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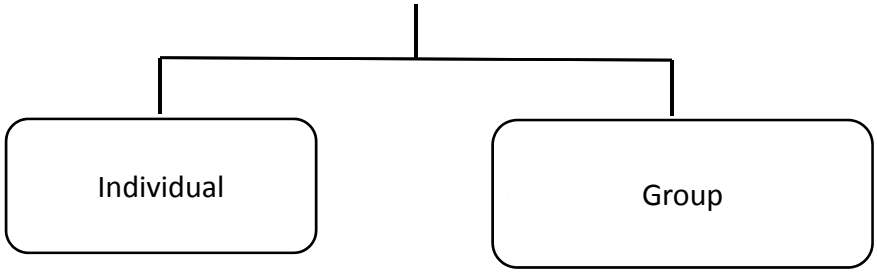
Individual vs. Group Reporting

Options



1. Individual — under a NPI number and TIN where they reassign benefits

2. As a Group
   a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*
   b) As an APM Entity

* If clinicians participate as a group, they are assessed as a group across all four MIPS performance categories.

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Submission Methods

	Individual	Group
Quality	• Qualified Clinical Data Registry (QCDR) • Qualified Registry • EHR • Claims	• QCDR • Qualified Registry • EHR • Administrative Claims • CMS Web Interface • CAHPS for MIPS Survey
Improvement Activities	• QCDR • Qualified Registry • EHR • Attestation	• QCDR • Qualified Registry • EHR • CMS Web Interface • Attestation
Advancing Care Information	• QCDR • Qualified Registry • EHR • Attestation	• QCDR • Qualified Registry • EHR • Attestation • CMS Web Interface

CAHPS = Consumer Assessment of Healthcare Providers and Systems

30 Source: The Centers for Medicare & Medicaid Services 30

Submission Methods: Helpful Information

Submission Mechanism	How Does It Work?
Qualified Clinical Data Registry (QCDR)	A QCDR is a CMS-approved entity that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. Each QCDR typically provides tailored instructions on data submission for eligible clinicians. e.g. ASIPP'S National Interventional Pain Management (NIPM) QCDR
Qualified Registry	A Qualified Registry collects clinical data from an eligible clinician or group of eligible clinicians and submits it to CMS on their behalf.
Electronic Health Record (EHR)	Eligible clinicians submit data directly through the use of an EHR system that is considered certified EHR technology (CEHRT). Alternatively, clinicians may work with a qualified EHR data submission vendor (DSV) who submits on behalf of the clinician or group.
Attestation	Eligible clinicians prove (attest) that they have completed measures or activities.
CMS Web Interface	A secure internet-based application available to pre-registered groups of clinicians. CMS loads the Web Interface with the group's patients. The group then completes data for the pre-populated patients.
Claims	Clinicians select measures and begin reporting through the routine billing processes.

31 Source: The Centers for Medicare & Medicaid Services

MIPS Scoring

What Do I Need to Know?

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MIPS Scoring for Quality (60 Percent of Final Score in Transition Year)

Select 6 of the approximately 300 available quality measures (minimum of 90 days)
- Or a specialty set
- Or CMS Web Interface measures

Clinicians receive 3 to 10 points on each quality measure based on performance against benchmarks.

Failure to submit performance data for a measure = 0 points.

Quick Tip:
Easier for a clinician who participates longer to meet case volume criteria needed to receive more than 3 points.

Bonus points are available
- 2 points for submitting an additional outcome measure
- 1 point for submitting an additional high-priority measure
- 1 point for using CEHRT to submit measures electronically end-to-end

33 Source: The Centers for Medicare & Medicaid Services

Choose Your Measures/Activities

How do I do this?

- Go to qpp.cms.gov.
- Click on the Explore Measures at the top of the page.
- Select the performance category of interest.

  Quality Measures | Advancing Care Information | Improvement Activities
- Review the individual Quality and Advancing Care Information measures as well as Improvement Activities.

34 Source: The Centers for Medicare & Medicaid Services

MIPS Performance Category: Cost

- No reporting requirement; 0 percent of final score in 2017
- Clinicians assessed on Medicare claims data
- CMS will still provide feedback on how you performed in this category in 2017, but it will not affect your 2019 payments.

Keep in mind:

Uses measures previously used in the Physician Value-Based Modifier program or reported in the Quality and Resource Use Report (QRUR)	Only the scoring is different

35 Source: The Centers for Medicare & Medicaid Services

MIPS Performance Category: Improvement Activities

- 15 percent of Final Score in 2017
- Attest to participation in activities that improve clinical practice
  - Examples: Shared decision making, patient safety, coordinating care, increasing access
- *Clinicians choose* from 90+ activities under 9 subcategories:

1. Expanded Practice Access	2. Population Management	3. Care Coordination
4. Beneficiary Engagement	5. Patient Safety and Practice Assessment	6. Participation in an APM
7. Achieving Health Equity	8. Integrating Behavioral and Mental Health	9. Emergency Preparedness and Response

36 Source: The Centers for Medicare & Medicaid Services

Basic QPP Rules for Improvement Activities Submissions

- Rewards practice improvement activities
- Choose from over 90 activities that suit practice's scope.
- Full credit for PCMH* accreditation; partial credit for APM participation
- Activities are weighted; earn up to 40 points.

Sample Practice Improvement Activities

- ✓ Implementation of at least one additional recommended activity from the Quality Innovation Network-Quality Improvement Organization after technical assistance has been provided related to improving care coordination.
- ✓ 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

*Patient-Centered Medical Home
** Transforming Clinical Practice Initiative

Source: The Centers for Medicare & Medicaid Services

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MIPS Scoring for Improvement Activities (15 Percent of Final Score in Transition Year)

Total points = 40

Activity Weights
- Medium = 10 points
- High = 20 points

Alternate Activity Weights*
- Medium = 20 points
- High = 40 points

*For clinicians in small, rural, and underserved practices or with non-patient facing clinician groups

Full credit for clinicians in a patient-centered medical home, Medical Home Model, or similar specialty practice

38 Source: The Centers for Medicare & Medicaid Services

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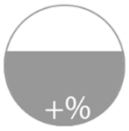
Improvement Activity: Requirements for the Transition Year

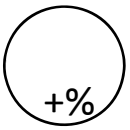
Submit Something

- **Test Means:**
  - Attesting to 1 Improvement Activity
  - Activity can be high or medium weight
  - In most cases, to attest you need to indicate that you have done the activity for 90 days.

For a full list of measures, please visit **QPP.CMS.GOV**



Submit a Partial Year



Submit a Full Year

- **Partial and Full Means:**
  - Attesting to 1 of the following combinations:
    - 2 high-weighted activities
    - 1 high-weighted activity and 2 medium-weighted activities
    - At least 4 medium-weighted activities
  - Clinicians with special considerations
    - 1 high-weighted activity
    - 2 medium-weighted activities

39 Source: The Centers for Medicare & Medicaid Services

MIPS Performance Category: Advancing Care Information (ACI)

- **25** percent of the Final Score in 2017
- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Ends and replaces the Medicare EHR Incentive Program (also known as Medicare Meaningful Use)
- Greater flexibility in choosing measures
- In 2017, there are ***2 measure sets for reporting based on EHR*** edition:

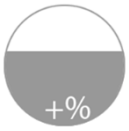
Advancing Care Information Objectives and Measures	2017 Advancing Care Information Transition Objectives and Measures

40 Source: The Centers for Medicare & Medicaid Services

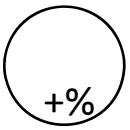
ACI: Requirements for the Transition Year

Submit Something

- **Test Means:**
  - Submitting 4 or 5 base score measures
    - Depends on use of 2014 or 2015 Edition
  - Reporting all required measures in the base score to earn any credit in the Advancing Care Information performance category



Submit a Partial Year



Submit a Full Year

- **Partial and Full Means:**
  - Submitting more than the base score in the Transition Year

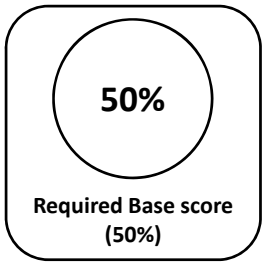
For a full list of measures, please visit QPP.CMS.GOV.

41 Source: The Centers for Medicare & Medicaid Services

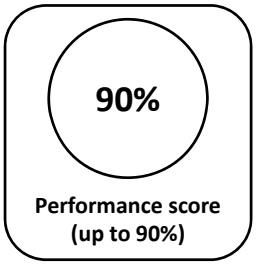
MIPS Performance Category: ACI (25 Percent of Final Score in Transition Year)

- **Earn up to 155 percent maximum score**, which will be capped at 100 percent.

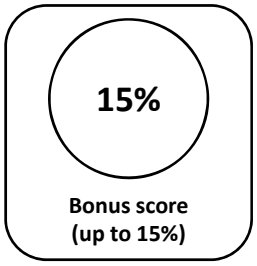
ACI category score includes:



Required Base score (50%)



Performance score (up to 90%)



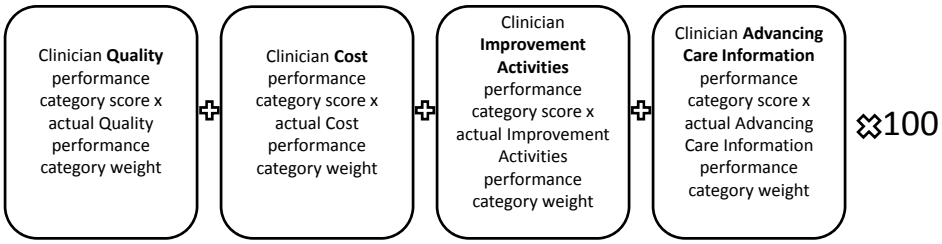
Bonus score (up to 15%)

Keep in mind: You need to fulfill the Base score or you will get a zero in the Advancing Care Information Performance Category.

42 Source: The Centers for Medicare & Medicaid Services

Calculating the Final Score Under MIPS

Final Score =



43 Source: The Centers for Medicare & Medicaid Services

Transition Year 2017

Final Score	Payment Adjustment
≥70 points	• Positive adjustment • Eligible for exceptional performance bonus—minimum of additional 0.5%
4–69 points	• Positive adjustment • Not eligible for exceptional performance bonus
3 points	• Neutral payment adjustment
0 points	• Negative payment adjustment of -4% • 0 points = does not participate

44 Source: The Centers for Medicare & Medicaid Services

Summary

Preparing and Participating in MIPS: A Checklist

- Determine your eligibility and understand the requirements.
- Choose whether you want to submit data as an individual or as a part of a group.
- Choose your submission method and verify its capabilities.
- Verify your EHR vendor or registry's capabilities before your chosen reporting period.
- Prepare to participate by reviewing practice readiness, ability to report, and the Pick Your Pace options.
- Choose your measures. Visit qpp.cms.gov for valuable resources on measure selection and remember to review your current billing codes and Quality Resource Use Report to help identify measures that best suit your practice.
- Verify the information you need to report successfully.
- Care for your patients and record the data.
- Submit your data by March 2018.

 Source: The Centers for Medicare & Medicaid Services

Choose a Submission Method and Verify Its Capabilities

How do I do this?

- Review the available submission options for 2017.
  - Speak with your specialty society about your options.
  - Consider using a Technical Assistance program (TCPI, QIN-QIOs, QPP-SURS) for decision support.
  - Visit qpp.cms.gov for information on submission options.
- Choose a submission option.
  - For Qualified Registries, QCDRs, and CAHPS for MIPS Survey:
    - Check that each of the submission options are approved by CMS.
  - For EHR reporting:
    - Check that your EHR is certified by the Office of the National Coordinator for Health Information Technology.

TCPI = Transforming Clinical Practice Initiative;
QPP-SURS = Quality Payment Program-Small, Underserved & Rural Support

47 Source: The Centers for Medicare & Medicaid Services

No-Cost QPP Support

- Visit https://www.hsag.com/QPP
- Call 1.844.472.4227
- Email HSAGQPPsupport@hsag.com

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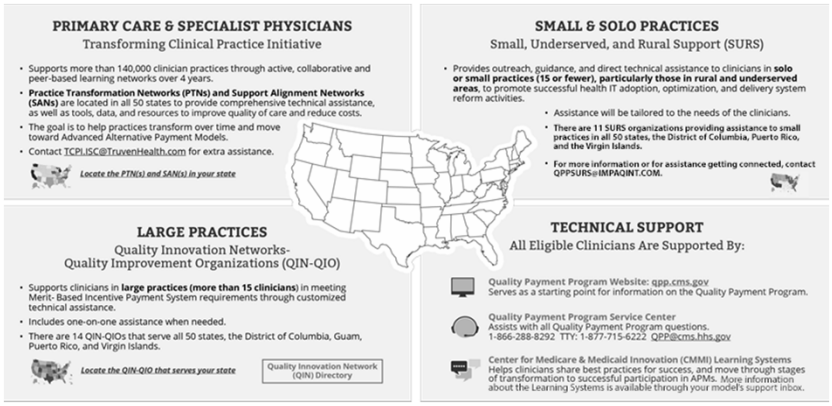
Technical Assistance for Clinicians

CMS has free resources and organizations on the ground to provide help to clinicians who are eligible for the QPP:



49 Source: The Centers for Medicare & Medicaid Services

Thank You

Howard Pitluk, MD, MPH, FACS
HSAG Vice President for Medical Affairs, Chief Medical Officer
602.801.6950 | hpitluk@hsag.com

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HSAG is an open, objective, and collaborative partner working across organizational, cultural, and geographic boundaries to share knowledge and resources with all stakeholders.

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