MACRA and MIPS Update 2017

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Objectives

- List and characterize the 4 major categories of MIPS
- Define who is an eligible clinician (EC) under the MIPS program now and in the future
- Describe how the MIPS program in 2017 will be scored and what payment adjustments are in effect

Physician Readiness

- Off all physicians…
  - 29% have not heard of MACRA
  - 40% not heard of MIPS
    - Medscape survey data

- Of physicians who have heard of MACRA and are involved in decision-making around the QPP…
  - 41% have heard of MACRA and QPP but knowledge ends there
  - 51% were somewhat knowledgeable about MACRA and QPP
  - 8% were “deeply knowledgeable”
    - KPMG survey data

MACRA

Medicare

Access &

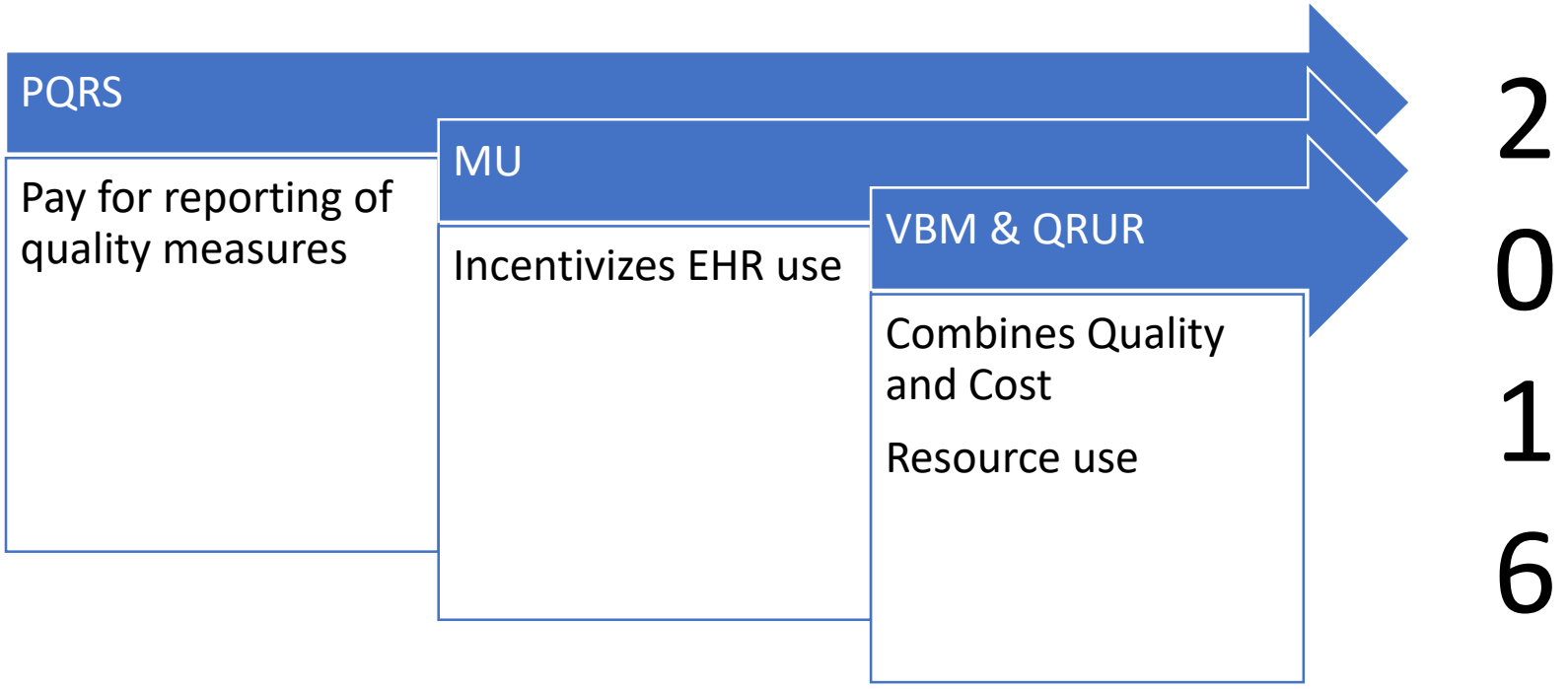
Chip

Reauthorization

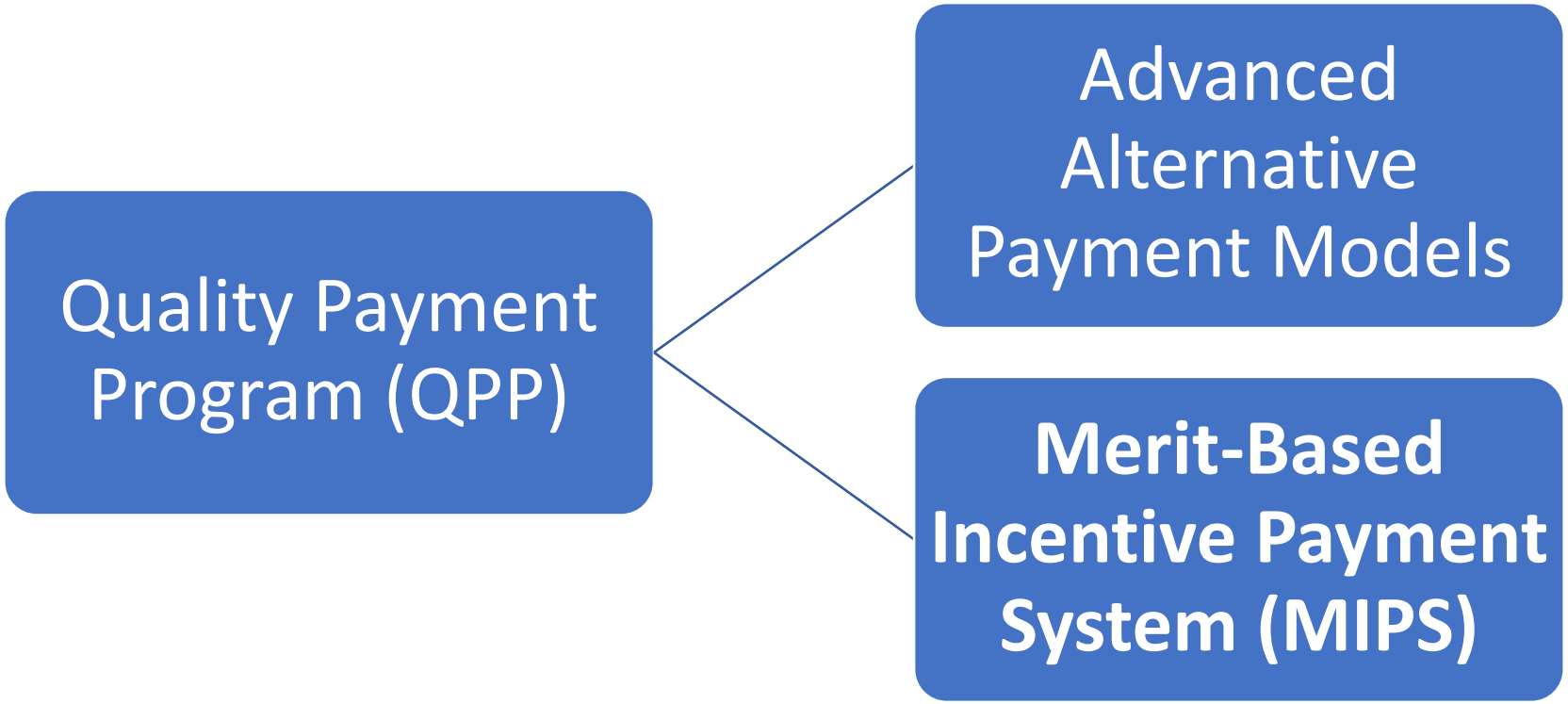
Act

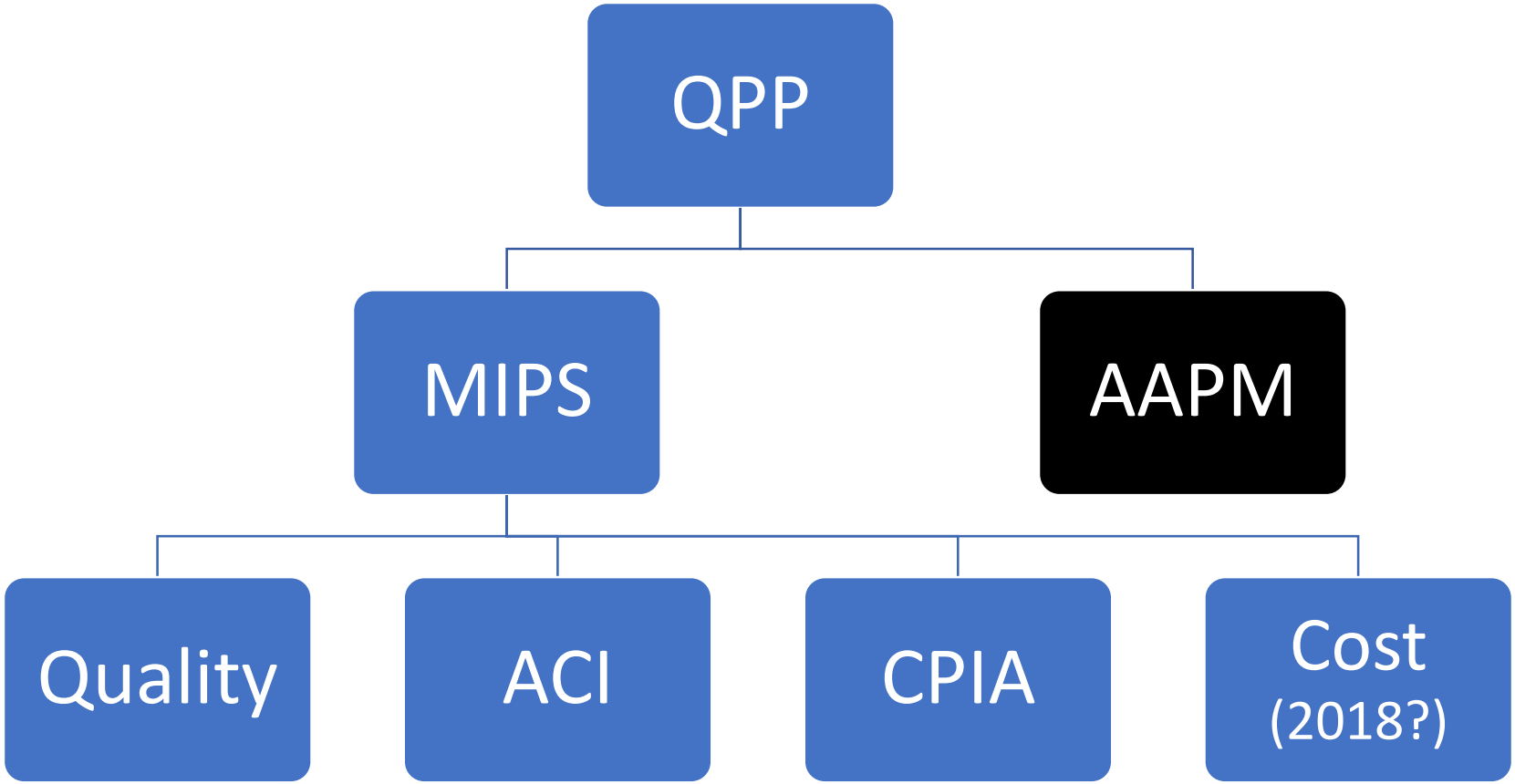
- "SGR repeal law"
- "Doc fix"
- Signed into law April 2015
- Took effect January 1, 2017

MediCARE Incentive Programs "Sunset" in 2016 - ACA



QPP – Medicare linking fee for service to triple aim





Quality – New version of PQRS

ACI – Advancing Care Information (new version of MU)

CPIA – Clinical Practice Improvement Activities

This is a competition

Program	Applies To	Negative Adjustments	Positive Adjustments
MIPS Adjustments	85% of providers	$833 Million	$833 Million
Exceptional Performance Payments			$500 Million
Advanced APM Incentives	15% of providers		$146 M - $429 M

How is MIPS scored?

Category Score

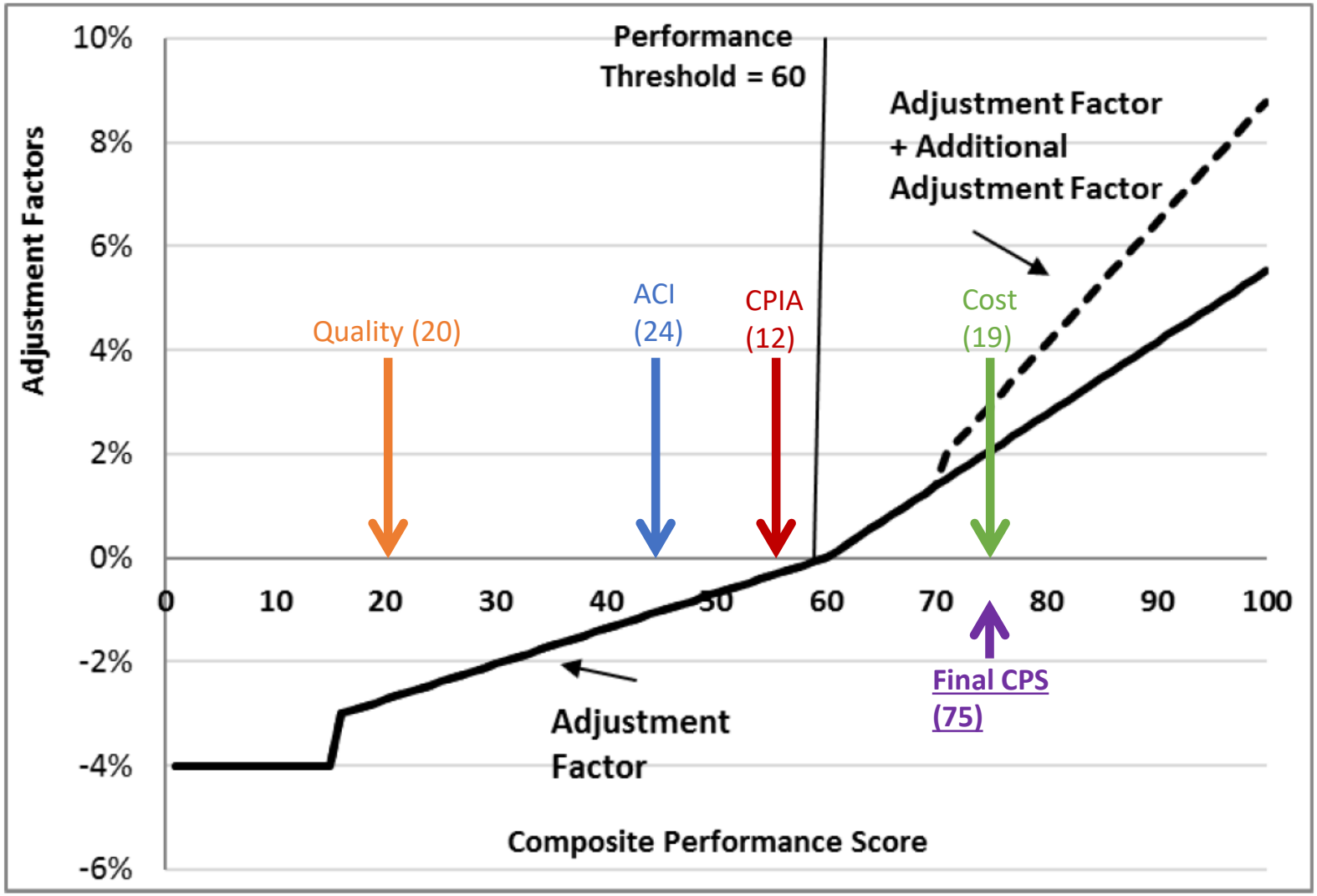
Category Score

Category Score

Category Score

Final Score

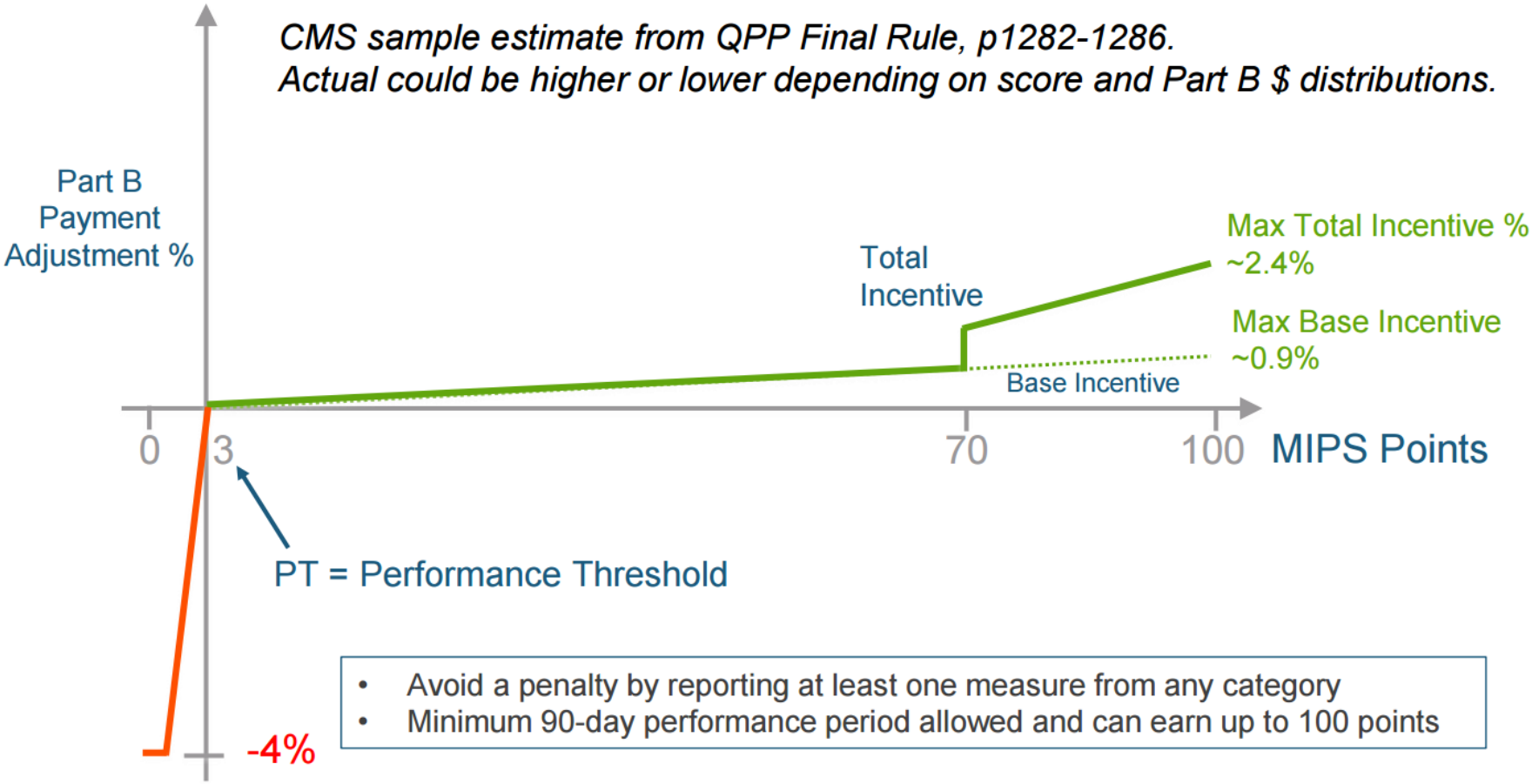
FIGURE A: Illustrative Example of MIPS Adjustment Factors Based on Composite Performance Scores (CPS)



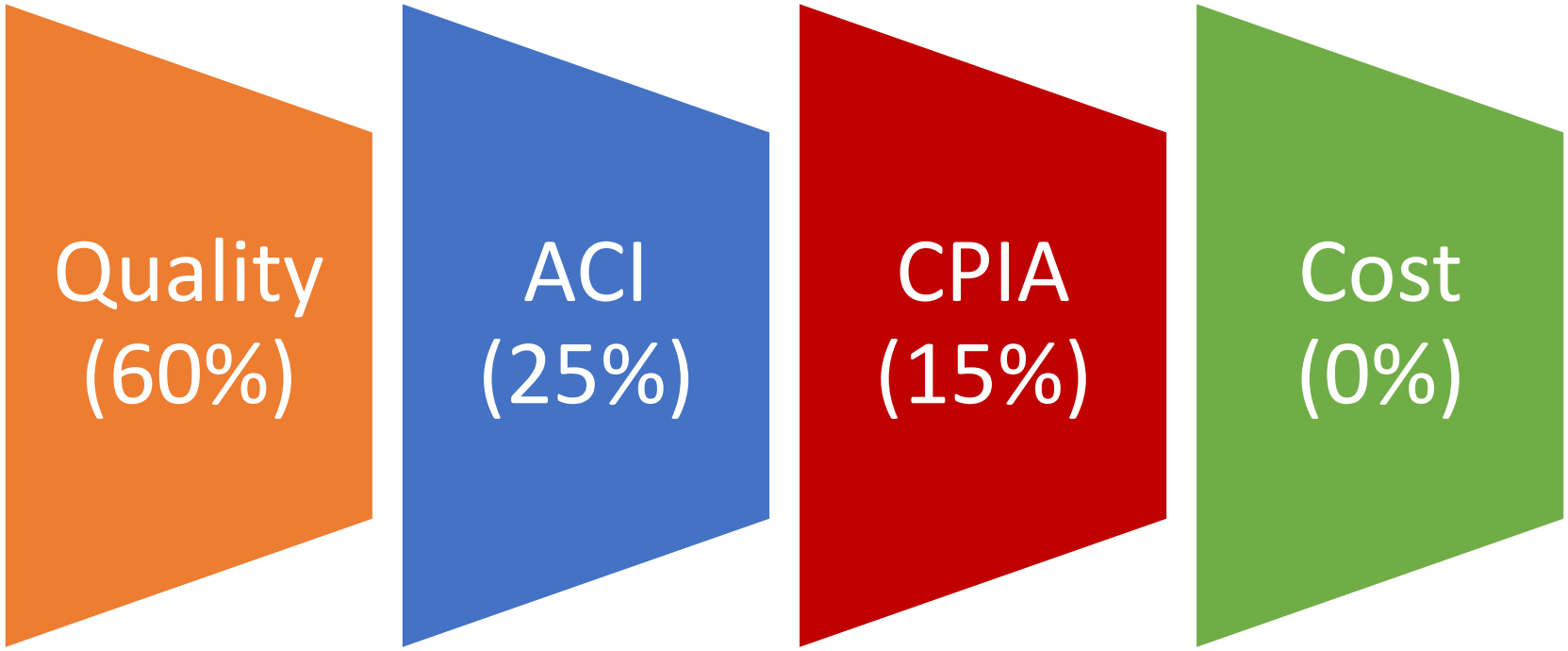
2017 is “Transitional Year”

- Essentially a “practice” or “warm up” year
- Can still get penalized 4% but only if you submit zero data
- “In the future…”
- “Future rulemaking…”

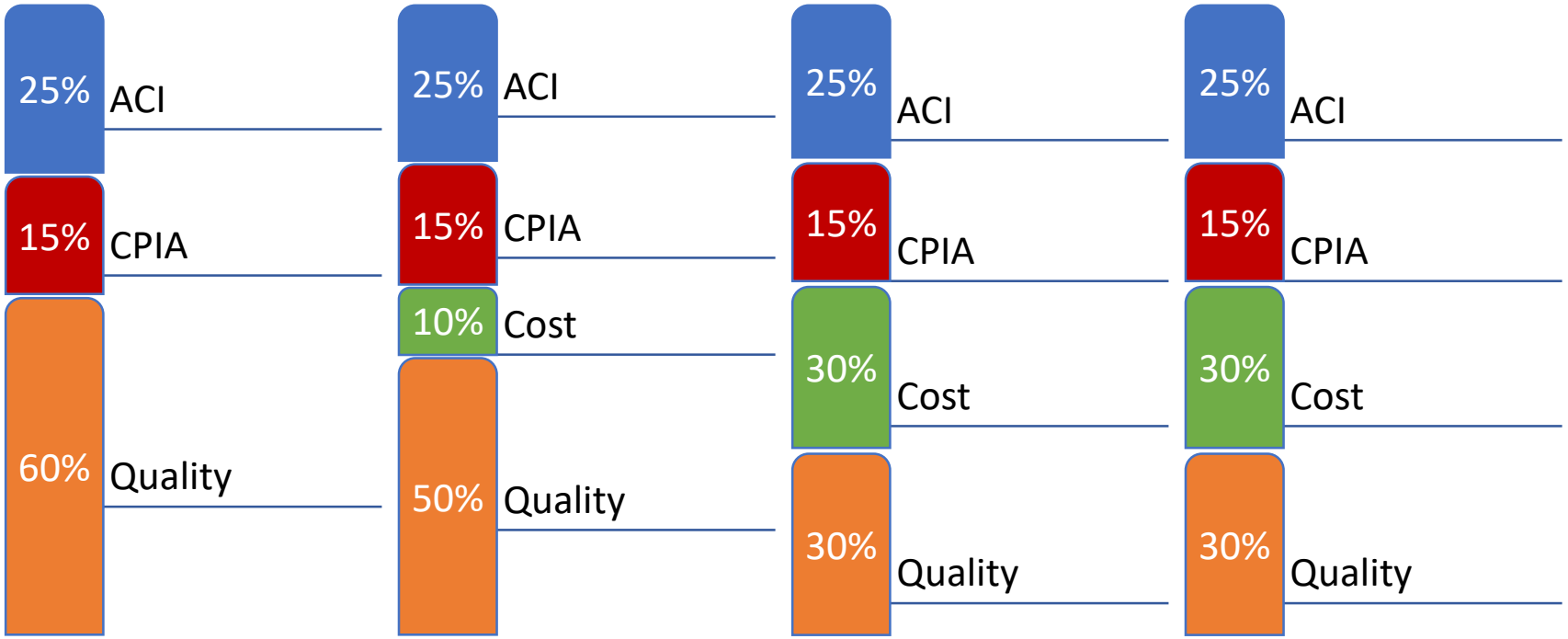
“Pick Your Pace”



How is MIPS scored in 2017?



MIPS Weighted Categories



2017 – 4%

2018 – 5%

2019 – 7%

2020 – 9%

Eligible clinicians (ECs) who bill Medicare Part B services MUST participate in MIPS.

2017 & 2018

- Physicians
- Nurse practitioners
- Physician assistants
- Certified nurse anesthetists
- Clinical nurse specialists

Possibly starting in 2019

- PT, ST, OT, social workers & more

Who Is Not Eligible

First year of Medicare Part B participation

Below **low patient volume** threshold

Medicare billing charges less than or equal to **$30,000 or provides care for 100** or fewer Medicare patients in one year

Certain participants in **ADVANCED** Alternative Payment Models

Clinician Attributes Impacting MIPS Scoring

Hospital based clinicians

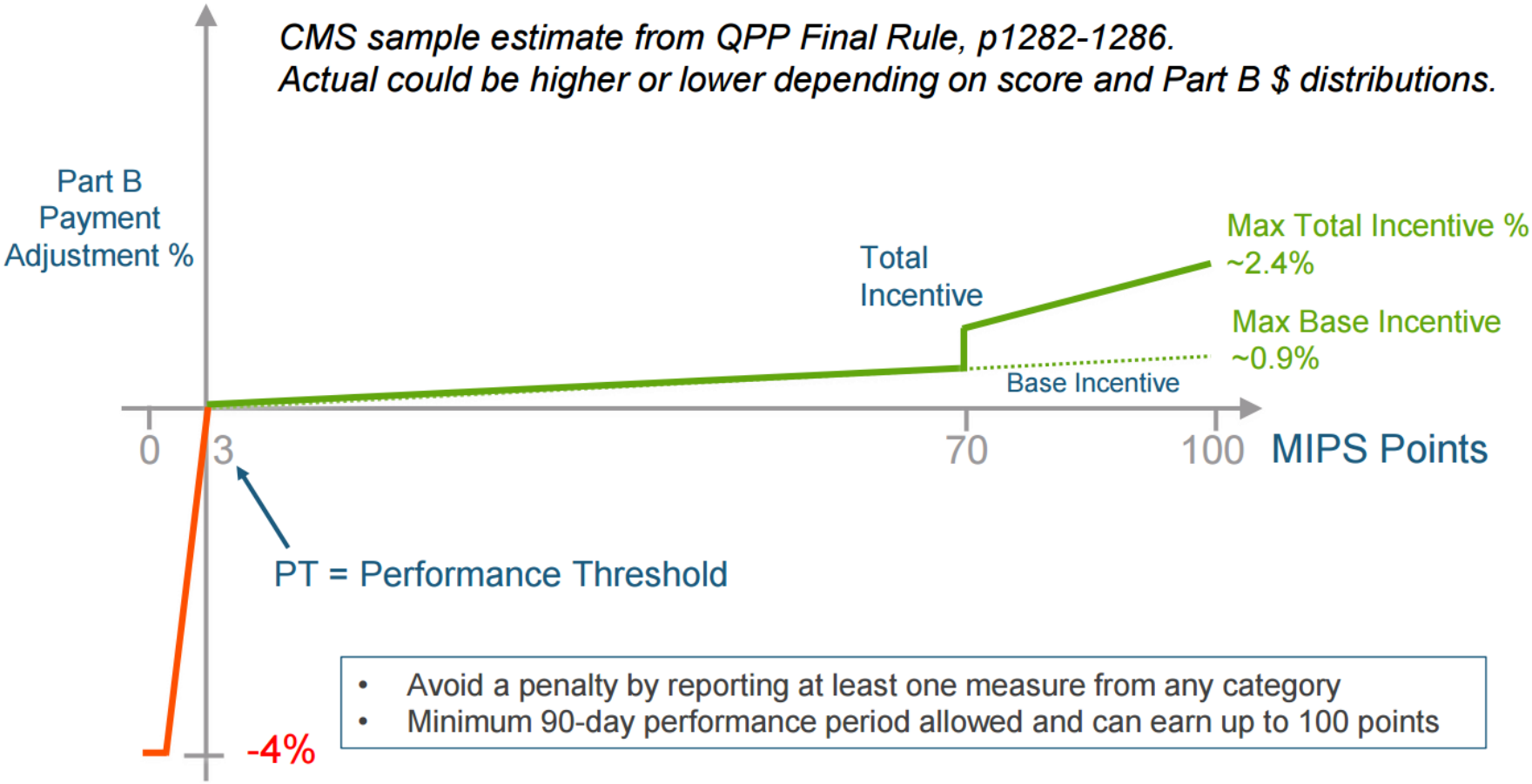
Non-patient facing clinicians

Small practices, practices located in rural areas or geographic HPSAs

“Pick Your Pace” for 2017

None	Test	Partial	Full
• Automatic negative 4% adjustment in 2019	• Report 1 quality measure OR • All ACI required measures • Avoid negative adjustment (neutral)	• More than 1 quality measure OR… • More than 1 improvement activity OR… • More than the 4 required ACI measures for at least 90 day period • Earn small positive adjustment based on score	• Report all required measures in all categories for at least a 90-day period and up to entire year • Earn modest positive adjustment • Exceptional performance

“Pick Your Pace”



MIPS Participation

Individual

NPI

Group

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

APM Entity Group

A collection of entities participating in an Alternative Payment Model

Quality

- Submit 6 Measures including:
  - 1 Outcome Measure
  - If no Outcome Measures available, another High Priority Measure:
    - Appropriate Use, Patient Safety, Efficiency, Patient Experience, Care Coordination
- If fewer than 6 measures apply, submit all that apply
- In 2018
  - 1 Cross-Cutting Measure (if ≥ 25 F2F visits)

National Quality Benchmarks

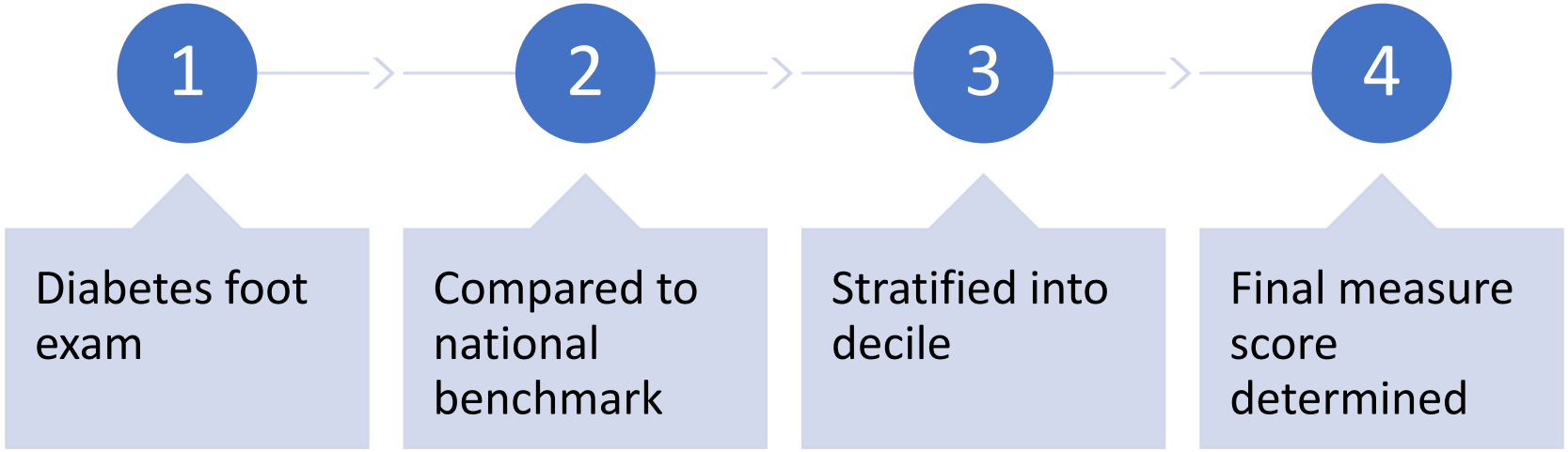
- Baseline Performance Period = 2 years prior to Performance Year
- All Specialties, Individuals, and Groups to Share Same Benchmarks
- Must have ≥ 20 Eligible Instances to Contribute to the Benchmark
- Zero Percent Performance will not be included in Benchmarks
- APM data included in the Benchmarks

2017 Individual Measure Scoring

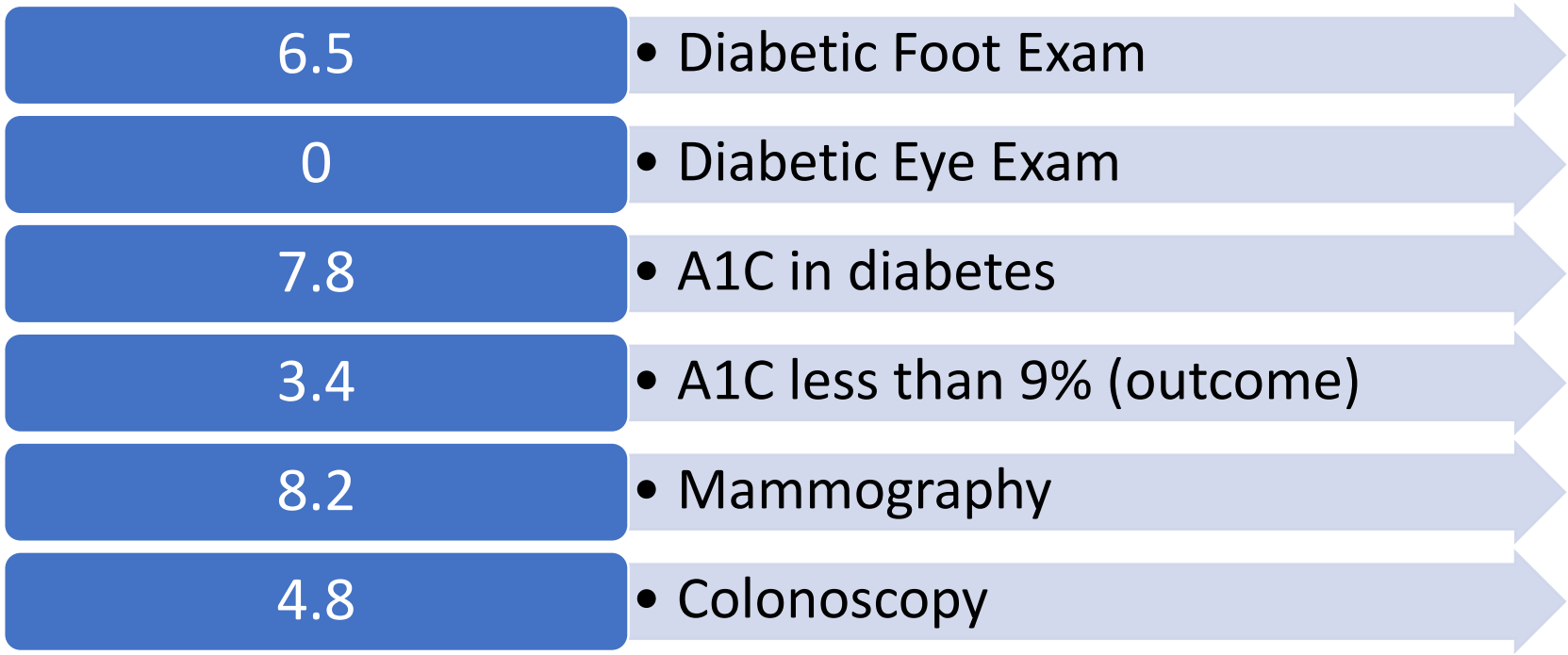
- Each measure scored on 3–10 scale
- Missing measure gets score = 0
- Must have a Benchmark to be scored
- Must have ≥ 20 Eligible Instances to be scored
- Top 6 measures are scored when extra measures submitted

Bonus Points Proposed

- Up to 10% (6 points in 2017) available as bonus points
- 1 point for each additional high priority measure submitted
- 1 point for each measure submitted electronically end-to-end

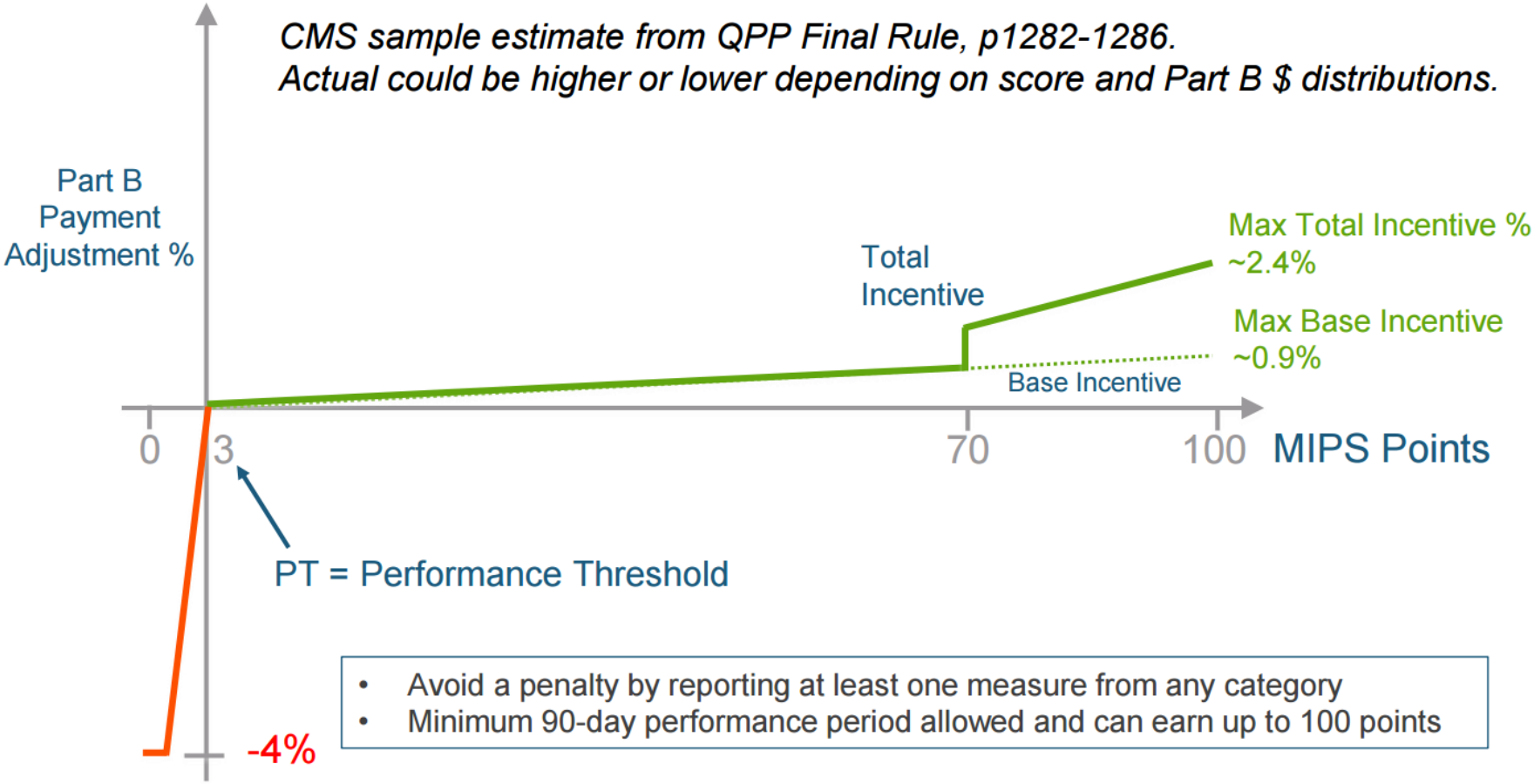


Calculating



30.7 of 60 quality points towards CPS

Only 1 measure…



ACI (25%)

- 4 required measures for Base Score (50 points)
- 7 optional measures for Performance Score (90 points)
- 15 bonus points available
- Maximum 100 points

Required measures for base score

ACI Measure	Required	Detail
Security Risk Assessment	Yes	Often done by EHR vendor
ePrescribing	Yes	Must do at least 1
Provide portal access	Yes	Must offer at least 1 patient
Health Information Exchange	Yes	Must send at least 1 TOC document (PAM)

Optional measures for performance score

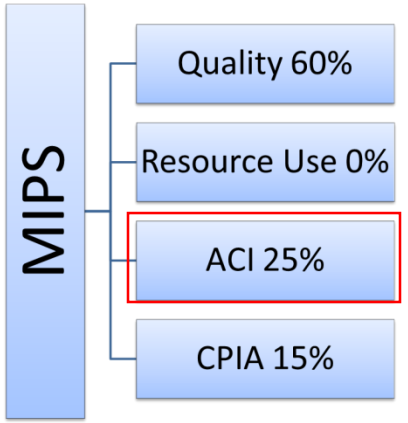
ACI Measure	Performance Points	Detail	Hypothetical Score
Provide patient access	0-20	Ask patients to sign up for portal	6
View, Download, or Transmit	0-10	Ask patients to use portal	2
Patient-Specific Education	0-10	Provide patient-specific education	9
Secure Messaging	0-10	Send patients messages	2
Health Information Exchange	0-20	Generate and send TOC documents with updated PAM	5
Medication Reconciliation	0-10	Perform medication reconciliation on all new patients	9
Immunization Reporting	0 or 10	Clinics that immunize will get 10, those that don't will get 0 points	0

33 points

Hypothetical ACI category score

Scoring

- There are 155 possible points to be earned
  - 50 Base
  - 90 Performance points
  - 15 Bonus points
- You are capped at 100



- 88 total points in our new example
- Means you earn 88% of 25 possible ACI Points
- **= 88% x 25 = 22 points**

CPIA (15%)

- Must reach 40 category points to receive full 15 points credit towards CPS
- PCMH certification = full 40 points automatically
- High-weighted measures = 20 points
- Medium-weighted measures = 10 points

High-Weight Activities

Expanded Practice Access	24/7 Availability of Advice with Access to Medical Record Expanded Weekday Hours and Weekend Hours Alternatives to one on one face to face care Open Access
Population Management	Anticoagulation Program Diabetic Glycemic Goals Qualified Clinical Data Registry participation
Care Coordination	CMS Transforming Clinical Practice Initiative
Beneficiary Engagement	Development of Improvement Plan based on Survey Data
Patient Safety and Practice Assessment	Use of the Prescription Drug Monitoring Program
Achieving Health Equity	Timely Visits with Medicaid Patients
Behavioral Health Integration	Co-location Targeted Care Management Services

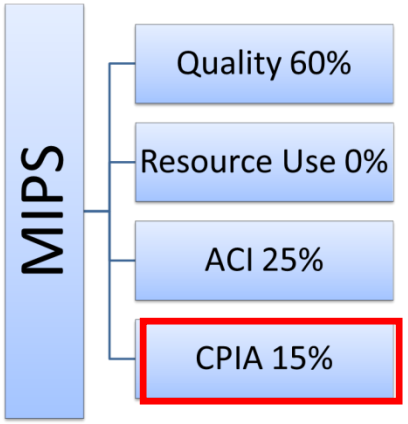
Medium-Weighted Activities (more than 82 CPIAs)

Expanded Practice Access	Use and Analysis of Telehealth Services
Population Management	Clinical Data Registry Participation
Care Coordination	Timely communication of test results
Beneficiary Engagement	Regularly assess patient experience
Patient Safety and Practice Assessment	Participation in CAHPS or supplemental questionnaire items
Achieving Health Equity	QCDR mediated collection of data using patient-reported outcome (PRO) tools
Emergency Response and Preparedness	Participation for min 6 months in domestic or international humanitarian volunteer work
Behavioral Health Integration	Diabetes screening for people with schizophrenia or bipolar disease who are using antipsychotic medication

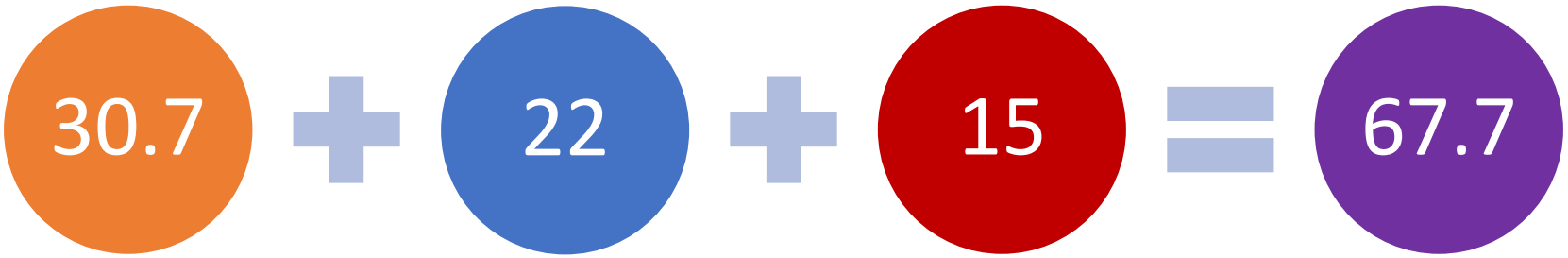
Scoring CPIA

Activity	Measure	Weight	Points	Total Possible Points
1	Expanded Practice Access	High	20	
2	Coumadin Clinic	High	20	
Total			40	40

- 40/40 = 100%
- 100% x 15 possible points
- = 15 points



Composite Performance Score 2017



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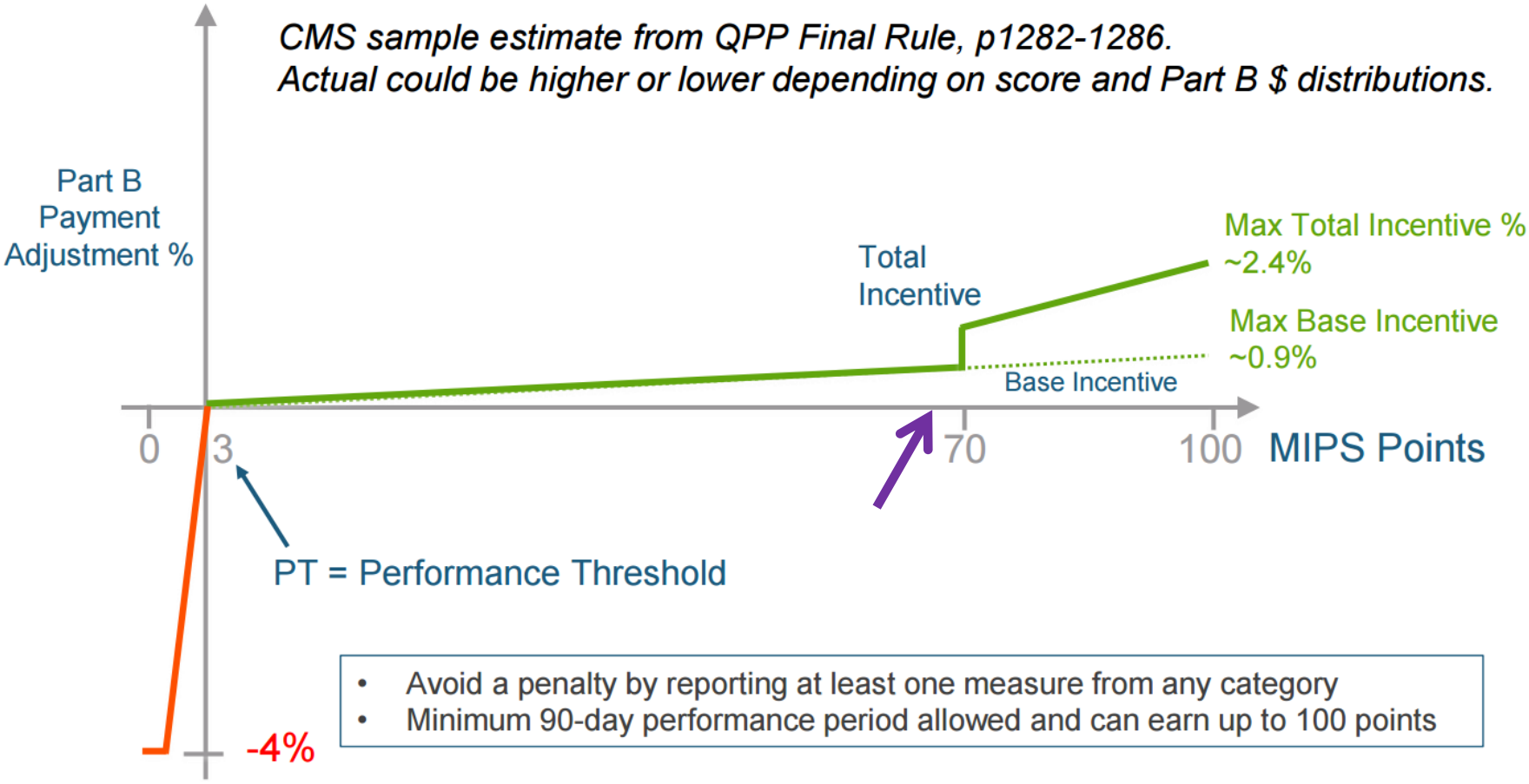
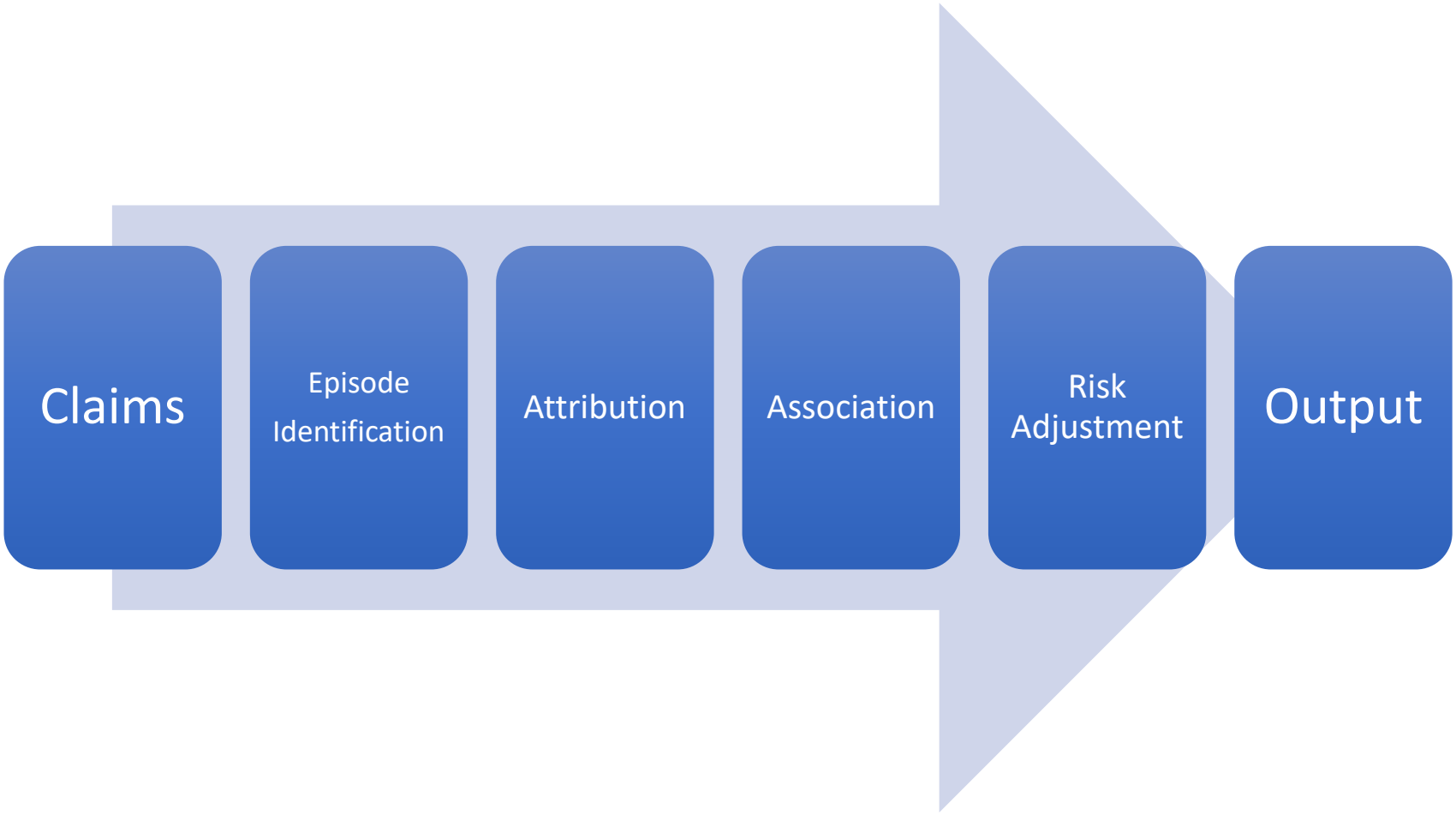


Resource Use (0% in 2017)

1. Total Costs per Capita for All Attributed Beneficiaries
2. Medicare Spending per Beneficiary (MSPB)
3. Episode Based Measures (New)
   - 31 Method A Measures
   - 7 Method B Measures

- Exclusions exist
  - Low volume
  - Newly enrolled
- Adjustments
  - Geographic
  - Risk (HCC codes)

Episodes of Care



Episodes of Care Examples

- AMI without PCI/CABG
- Chronic atrial fibrillation
- Ischemic stroke
- C. diff colitis
- UTI
- TKA
- Acute PE
- Osteoporosis

Resource Use Scoring Basics

- Score Each Measure on a 10 point scale
- Compare to Measure Specific Performance Period Benchmarks
- 20 case minimum to be included in Benchmark

Converting a Performance Rate to a Standard Score

Benchmark Decile	Hypothetical Resource Use	Scored
1	≥ $100,000	1.0 – 1.9
2	$75,893-$99,999	2.0 – 2.9
3	$69,003-$75,892	3.0 – 3.9
4	$56,009-$69,002	4.0 – 4.9
5	$50,300-$56,008	5.0 – 5.9
6	$34,544-$50,299	6.0 – 6.9
7	$27,900-$34,543	7.0 – 7.9
8	$21,656-$27,899	8.0 – 8.9
9	$15,001-$21,655	9.0 – 9.9
10	$1,000-$15,000	10

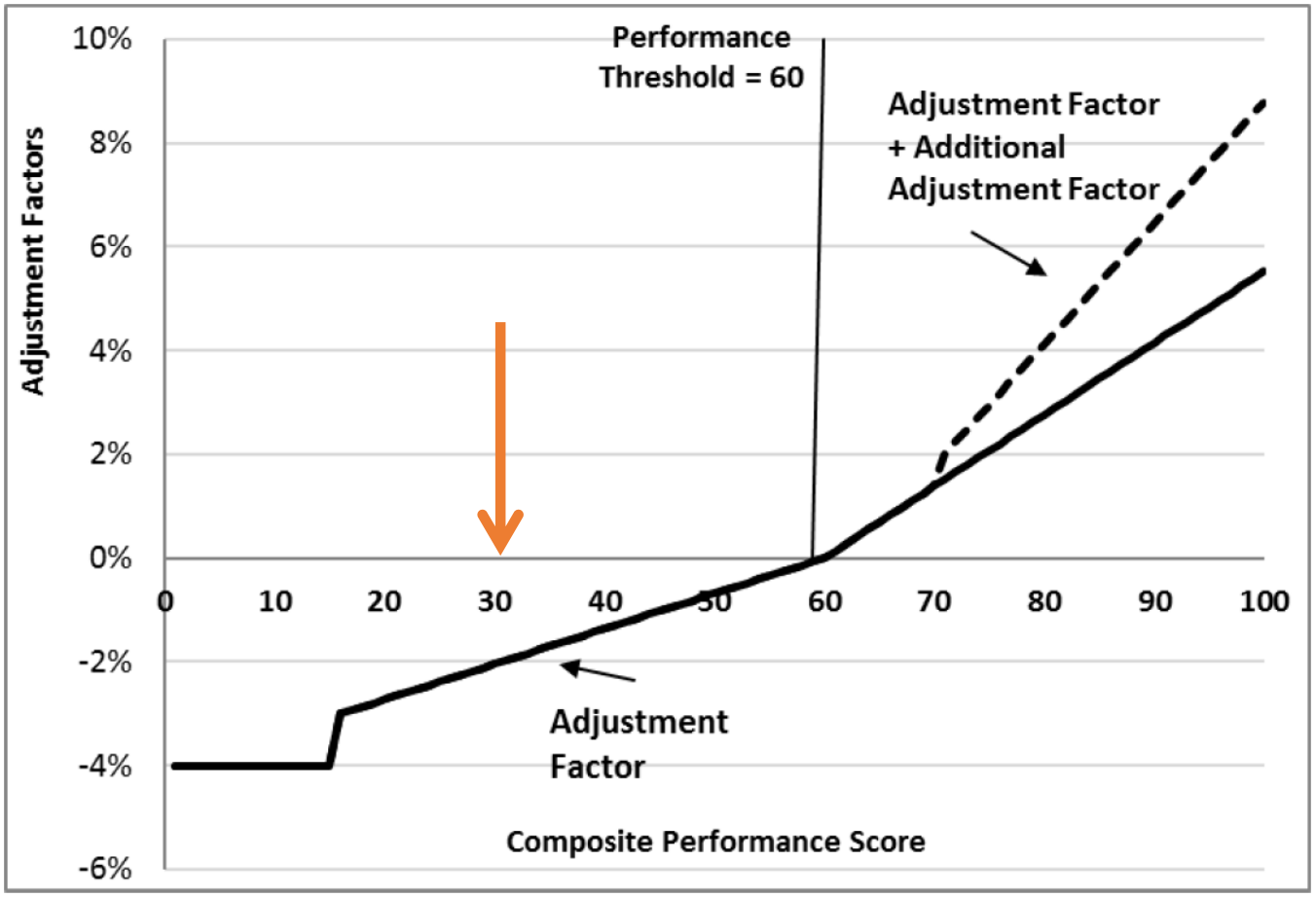
($56008 – $50300)/10
= $571
Every $571
increments 0.1 Score

Performance	Score
$56,008 to $55,437	5.0
$55,436 to $54,866	5.1
$54,865 to $54,295	5.2
$54,294 to $53,724	5.3
$53,723 to $53,153	5.4
$53,152 to $52,582	5.5
$52,582 to $52,011	5.6
$52,010 to $51,440	5.7
$51,439 to $50,869	5.8
$50,868 to $56,008	5.9

Measure	Type	Cases	Performance $	Median	Points	Total Possible
1	Medicare Spending Per Beneficiary	20	$15,000	$13,000	4.0	10
2	Total Per Capita Costs	21	$12,000	$10,000	4.2	10
3	Episode 1	22	$15,000	$18,000	5.8	10
4	Episode 2	10	$11,000	$9,000	Below Case Threshold	NA
5	Episode 3	45	$7,000	$10,000	8.3	10
Total Points					22.3	40

- 22.3 of 40 total possible points = 55.8%
- 55.8% of 10 = **5.6 points**

FIGURE A: Illustrative Example of MIPS Adjustment Factors Based on Composite Performance Scores (CPS)



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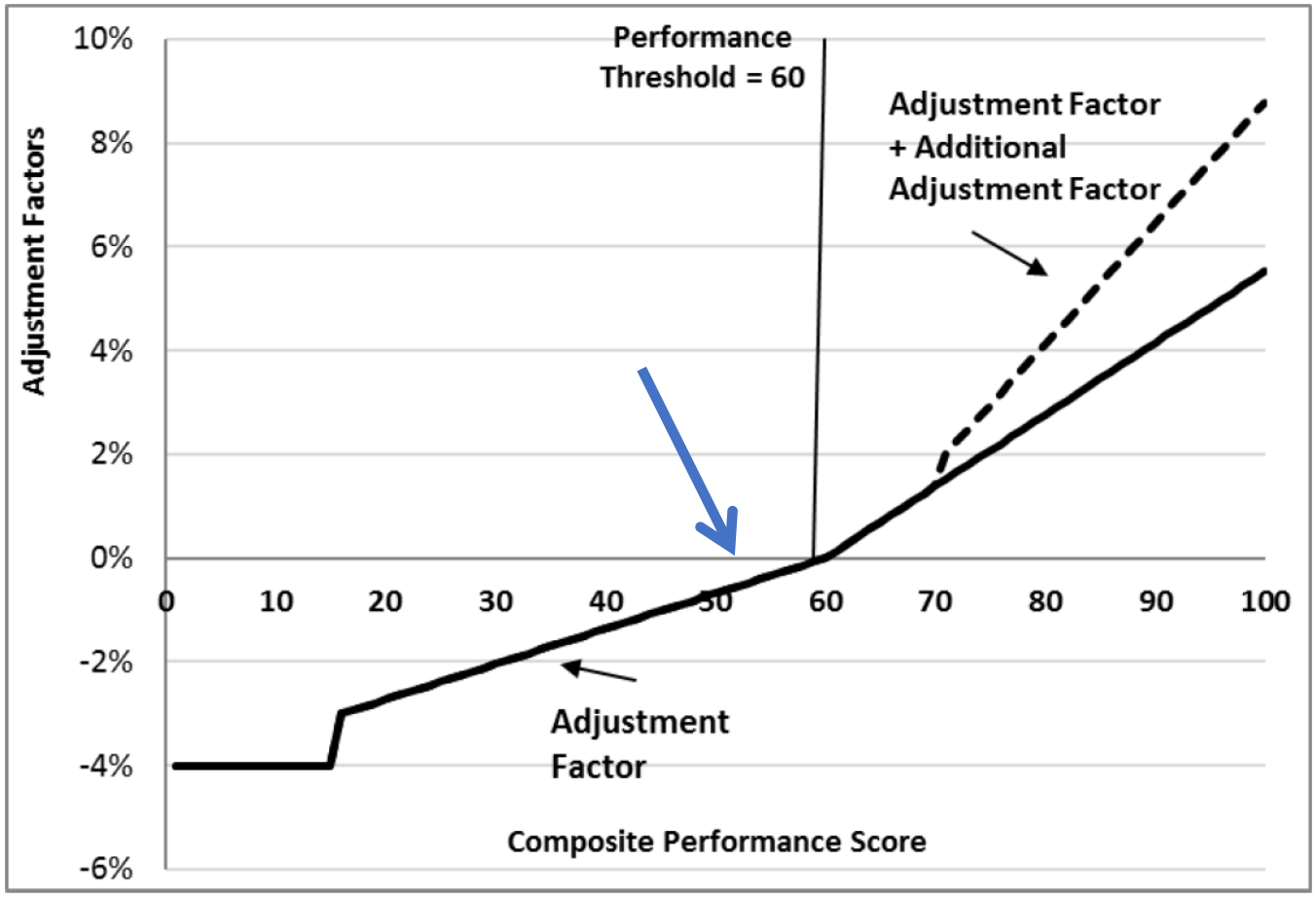

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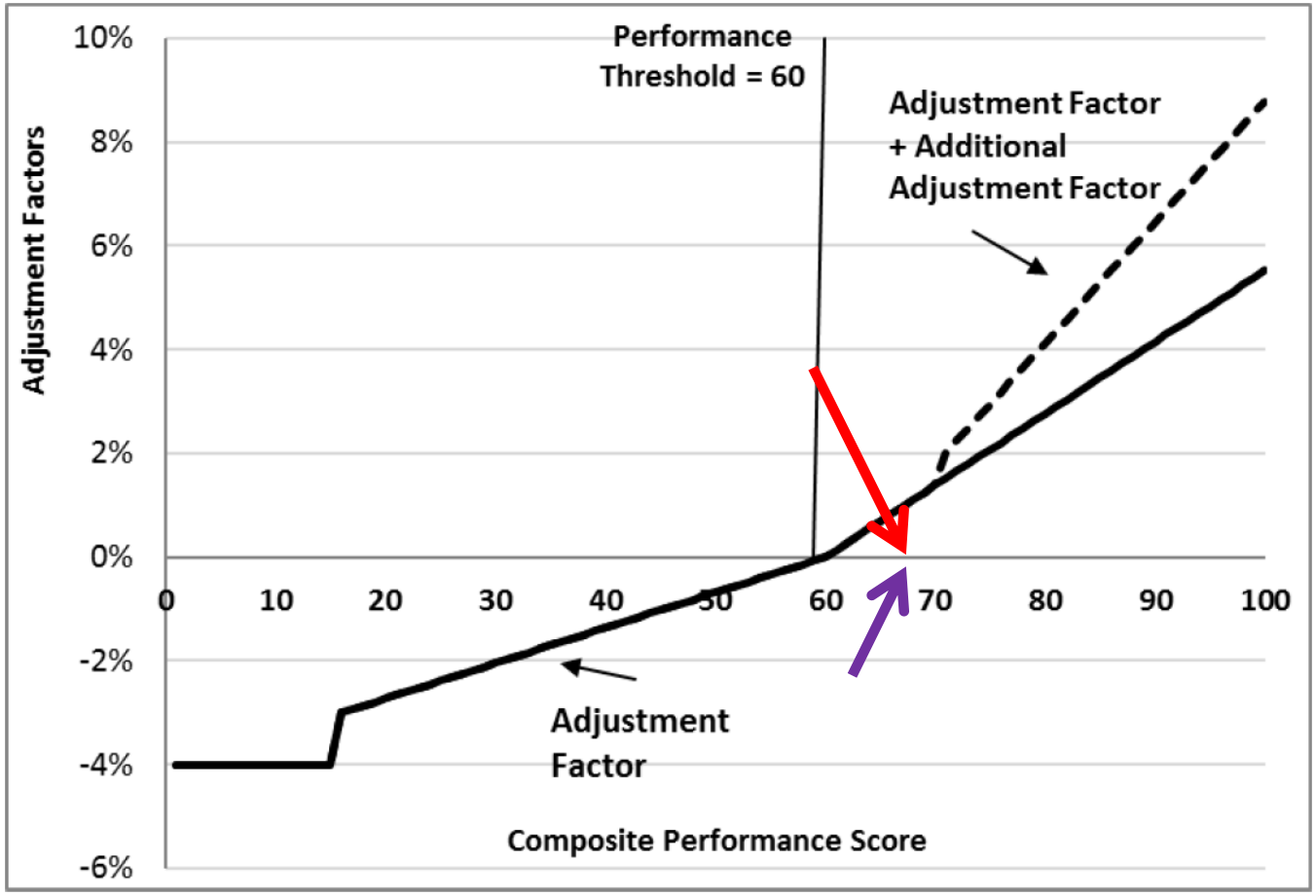


Why?

- CMS has goal to tie >90% of payments to quality by 2018

- This forces almost all providers into a 2-sided risk model

Practical Effects

- The solo practitioner will be at risk
- Pressure to join larger practices

Practice Size	Eligible Clinicians	Physician Fee Schedule Allowed Charges ($ Mil)	Percent Eligible Clinicians with Negative Adjust-ment
Solo	102,788	$12,458	87.0%
2-9 eligible clinicians	123,695	$18,697	69.9%
10-24 eligible clinicians	81,207	$9,934	59.4%
25-99 eligible clinicians	147,976	$12,868	44.9%
100 or more eligible clinicians	305,676	$18,648	18.3%
Overall	**761,342**	**$72,606**	**45.5%**

Future State

- MIPS expectations will not likely get easier
- CMS goal is to push practices towards Advanced APMs
- Force the APM to manage the risk
  - 5% increase in PFS

2017 Advanced APMs

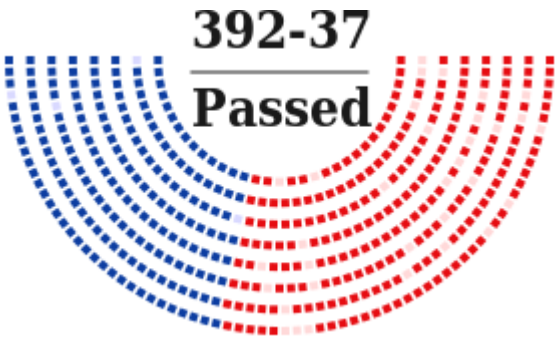
- MSSP Track 2
- MSSP Track 3
- Next Generation ACO
- CPC+
- Comprehensive ESRD Care Model

- 25% payments must be through the APM
- 20% patients must be in the APM

- 5% flat bonus payment
- Excluded from MIPS

MACRA vote

House vote



Senate vote