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GUIDEPOINT
Reimbursement Resources

MACRA
Quality Payment Programs

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Reimbursement Resources

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GUIDEPOINT
Reimbursement Resources

- THE PURPOSE OF THIS PRESENTATION IS TO PROVIDE YOU WITH GENERAL INFORMATION AND KEY CONSIDERATIONS RELATED TO THE **THE MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015 (MACRA).** THE INFORMATION PROVIDED IN THIS PRESENTATION HAS BEEN GATHERED FROM THIRD-PARTY SOURCES AND IS PRESENTED FOR ILLUSTRATIVE PURPOSES ONLY. THIS INFORMATION DOES NOT CONSTITUTE CODING, REIMBURSEMENT OR LEGAL ADVICE. NEITHER HCPRO NOR BOSTON SCIENTIFIC MAKES ANY REPRESENTATION OR WARRANTY REGARDING THIS INFORMATION OR ITS COMPLETENESS, ACCURACY, TIMELINESS, OR APPLICABILITY WITH A PARTICULAR PATIENT OR PROCEDURE. HCPRO AND BOSTON SCIENTIFIC SPECIFICALLY DISCLAIM LIABILITY OR RESPONSIBILITY FOR THE RESULTS OR CONSEQUENCES OF ANY ACTIONS TAKEN IN RELIANCE ON INFORMATION PRESENTED HERE TODAY.

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Agenda

- MACRA and Quality Payment Programs – Background
- Transition
- Eligible Participants
- Payment Paths for Physicians
- Transitional Reporting Options, Requirements, Risks, and Benefits
- Qualities Measures
- Payment Adjustments
- Score Calculations

MACRA at a Glance

Medicare Access and CHIP Reauthorization Act of 2010 – MACRA

Signed into Law on April 16th, 2010

- Landmark bipartisan legislation
- Framework for health care providers to successfully take part in the CMS Quality Payment Program that rewards value and outcomes
- Intended to simplify the administrative processes for physicians
- Permanently repealed the Sustainable Growth Rate (SGR) formula
- Established annual updates to the conversion factor

MACRA at a Glance

Medicare Access and CHIP Reauthorization Act of 2010 – MACRA

- Title I of MACRA
  - Repeals the Sustainable Growth Rate (SGR) Formula
  - Modification to Medicare reimbursement - rewards clinicians for value over volume
  - Simplifies/combines multiple quality programs under the new Merit Based Incentive Payments System (MIPS)
  - Provides bonus payments for participation in eligible alternative payment models (APMs)

MACRA, Quality and Intended Goals

Intended Goals of MACRA

- Multiple pathways
  - Variable levels of risk
- Reward for providers to link payment to value
- Opportunity of expansion for of providers to participate in APMs
- Minimize reporting burdens for APM participants
- Increase understanding of each physician's or practitioner's MIPS and/or APM status
- Support multi-payer initiatives
  - Development of APMs in Medicaid, Medicare Advantage, and other payer arrangements.

Two Pathways

- MACRA was designed to offer physicians a choice between two payment pathways:
  - Merit Based Incentive Programs (MIPS)
    - A modified fee-for-service model
  - Alternate Payment Models
    - Reduce costs of care
    - Support high-value services not typically covered under the Medicare fee schedule
- CMS named the physician payment system created by MACRA the Quality Payment Program (QPP)

Merit Based Incentive Programs (MIPS)

MIPS

- Aligns 3 independent programs
  - PQRS, VM, and MU incentives
- Adds a fourth component to promote improvement and innovation
  - Improvement Activities
- Provides flexibility and choice of measures to the providers
- Allows the retention of a fee-for-service payment option

MIPS Components

- Quality Reporting
  - Formerly PQRS
- Cost
  - formerly Value-based Modifier
- Advancing Care Information
  - Formerly meaningful use (MU)
- Improvement Activities

MIPS – Who May Participate?

- Eligible Clinicians
  - CMS has proposed that a MIPS eligible clinician be defined as the following licensed providers and any group that includes such professionals:
    - Doctors of Medicine (MD)
    - Doctors of Osteopathy (DO)
    - Doctors of Dental Surgery/Dental Medicine (DMD/DDS)
    - Doctors of Podiatry
    - Doctors of Optometry
    - Chiropractors
    - Physician Assistants (PA)
    - Nurse Practitioners (NP)
    - Clinical Nurse Specialists
    - Certified Registered Nurse Anesthetists

MIPS Exemptions

Exemption Based on Low Volume Threshold

- Physicians with Medicare allowed charges of $30,000 or less or 100 or fewer Medicare patients
- Eligibility calculated by CMS
  - Notification should occur in December (notification for 2017 is late)
  - Based on recent 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

MIPS and Non-Patient Facing Clinicians

- Eligible to participate in MIPS when they meet the following:
  - Exceed the low-volume threshold
  - Not newly enrolled,
  - 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% of NPIs billing under the group's TIN during a performance period are labeled as non-patient facing

Future Clinician Expansion

Eligible Clinician Expansion

- After three years of MACRA, the US Secretary of Health and Human Services has the option to expand the definition of a MIPS eligible clinicians to also include:
  - Physical Therapists
  - Occupational therapists
  - Speech-language pathologists
  - Audiologists
  - Nurse midwives
  - Clinical social workers
  - Clinical psychologists
  - Dietitians
  - Nutritional professionals

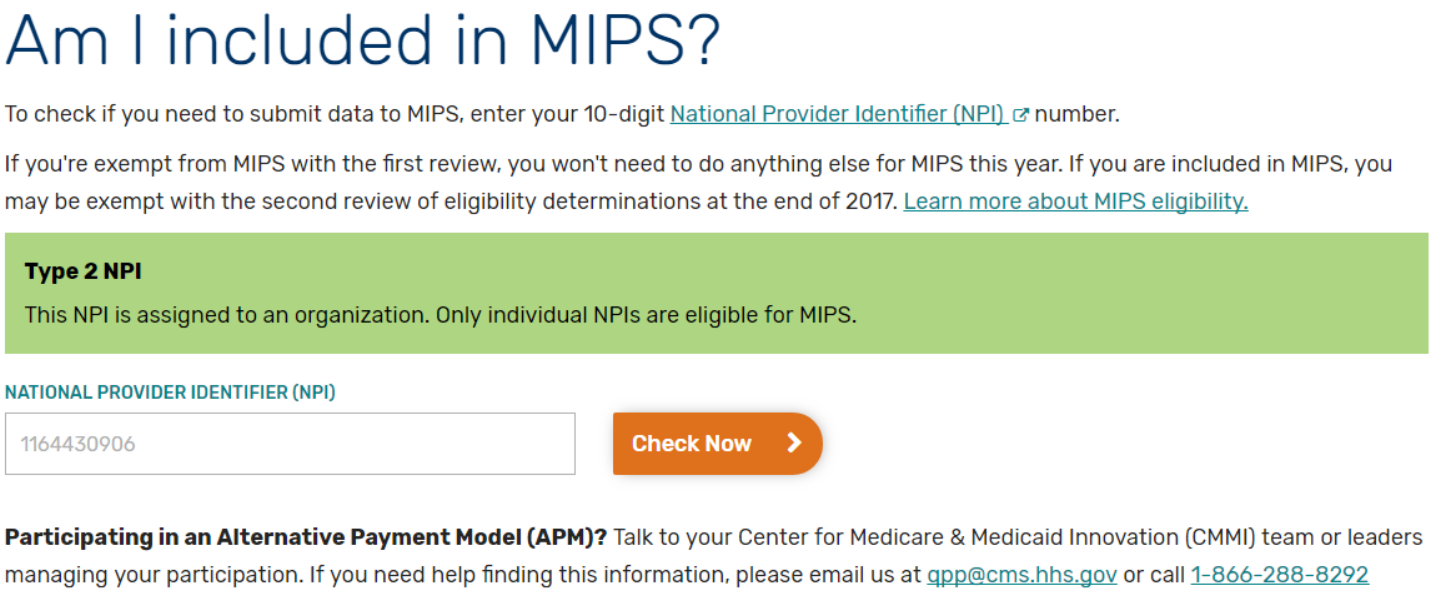
MIPS – When and How…

When to Begin?

- The Quality Program Reporting begins January 1, 2017
- Performance data collection can begin on January 1, 2017
- Not Ready?
  - Collection can begin any time between January 1 and October 2, 2017
- Independent of start date:
  - Performance data must be submitted by March 31, 2018
  - Payment adjustments based on performance will go into effect on January 1, 2019

Determining Participation Eligibility

- To determine if your required to submit data to MIPS access the "Am I Included in MIPS?"



Am I included in MIPS?

To check if you need to submit data to MIPS, enter your 10-digit National Provider Identifier (NPI) number.

If you're exempt from MIPS with the first review, you won't need to do anything else for MIPS this year. If you are included in MIPS, you may be exempt with the second review of eligibility determinations at the end of 2017. Learn more about MIPS eligibility.

Type 2 NPI

This NPI is assigned to an organization. Only individual NPIs are eligible for MIPS.

NATIONAL PROVIDER IDENTIFIER (NPI)

1164430906

Check Now

Participating in an Alternative Payment Model (APM)? Talk to your Center for Medicare & Medicaid Innovation (CMMI) team or leaders managing your participation. If you need help finding this information, please email us at qpp@cms.hhs.gov or call 1-866-288-8292

MIPS Reporting

Reporting Flexibility– Transitional Year 2017

- Providers can determine their level of participation
  - APM
  - MIPS
    - Test Pace
    - Partial Year
    - Full Year
- Failure to participate in the Quality Payment Program for the Transition Year will result in a negative 4 percent payment adjustment

MIPS – Levels of Participation

- Test Pace
  - Submit some data after January 1, 2017
  - Neutral or small payment adjustment
- Partial Year
  - Submit partial year
  - Report for 90-day period after January 1, 2017
  - Small positive payment adjustment
- Full Year
  - Submit full year
  - Fully participate starting January 1, 2017
  - Modest positive payment adjustment

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At Least Choose to Test for 2017

- Minimal amount of data
- Avoids a downward adjustment
- What is a minimum amount of data?
  - 1 quality measure OR
  - 1 Improvement Activity OR
  - 4 or 5 Advancing Care Information Measures

MIPS: Partial Participation for 2017

- Submit 90 days of 2017 data to Medicare
- Possibility of earning a positive payment adjustment
- Data can be submitted any time between January 1 and October 2, 2017
- Performance data must be sent by March 31, 2018

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MIPS – Full Year Participation

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

Requirements for Transition Year

Quality Requirements

- For Test Pace
  - Minimal data
- Partial and/or Full Participation
  - Submitting at least six quality measures, including at least one outcome measures, for a full year
- Full list of Measures is available at www.qpp.cms.gov

Quality Measures

Select Measures

SEARCH ALL BY KEYWORD

All | Search for... | SEARCH

FILTER BY:

High Priority Measure | Data Submission Method | Specialty Measure Set

Showing **271** Measures

Add All Measures

- Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy - Avoidance of Inappropriate Use — ADD
- Acute Otitis Externa (AOE): Topical Therapy — ADD
- ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication — ADD
- Adherence to Antipsychotic Medications For Individuals with Schizophrenia — REMOVE
- Adult Kidney Disease: Blood Pressure Management — ADD
- Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis — ADD

Selected Measures

6 Measures Added

Download (CSV) | Clear All

- Adherence to Antipsychotic Medications For Individuals with Schizophrenia
- Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions
- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

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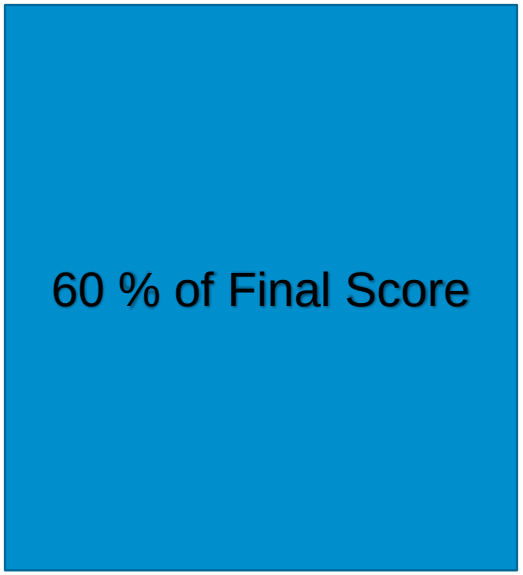
Individual vs. Group Reporting

- Individual
  - Submitted under an NPI number and tax identification number associated with reassignment of benefits
- Group
  - Two or more clinicians with NPIs reassigned to a single tax identification number
    - When clinicians participate as a group, they are assessed as group across all 4 MIPS performance categories

Understanding MIPS Performance Categories

MIPS Performance Categories

- Quality



33 Different requirements for groups reporting CMS Web Interface or those in MIPS APMs

May also select specialty-specific set of measures Select 6 of about 300 quality measures

Minimum of 90 days to be eligible for maximum payment adjustment

One measure must be an Outcome measure or High-priority measure

> High priority measures are defined as outcome measure, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination

May also select specialty-specific set of measures

Readmission measure for group submissions that have ≥ 16 clinicians and a sufficient number of cases (no requirement to submit)

Advancing Care Information

- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Ends and replaces Meaningful Use
- Greater flexibility in Measure Choice
- 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

Advancing Care Information

- Who Can Participate?
  - All MIPS Eligible Clinicians
    - Individual or Group
  - Optional Participants
    - Hospital-based MIPS clinicians,
    - Nurse Practitioners,
    - Physician Assistants,
    - Clinical Nurse Specialists,
    - CRNAs
- Not Eligible to Participate
  - Facilities – Skilled Nursing Facilities

MIPS Performance Categories

Advancing Care Information

- How to Report?
  - Must use certified EHR technology
  - 2015 Certified Edition
    - Two Options
      - Advancing Care Information Objectives and Measures
      - Combination of the two measure sets
  - 2014 Certified Edition
    - 2017 Advancing Care Information Transition Objectives and Measures
    - Combination of the two measure sets

Advancing Care Information Requirements for the Transition Year

Test Pace

- Submitting 4 or 5 base score measures
  - Submission depends of 2014/2015
- Must report all required measures in the base score to earn any credit in the advancing care information performance category

Partial and Full Participation

- Must submit more than the base score in the first year

MIPS Performance Category
Advancing Care Information

Advancing Care Information Objectives and Measures

Base Objective Measures

Objective	Measure
Protect Patient Health Information	Security Risk Analysis
Electronic Prescribing	e-Prescribing
Patient Electronic Access	Provide Patient Access
Health Information Exchange	Send a Summary of Care
Health Information Exchange	Request/Accept a Summary of Care

2017 Advancing Care Information Transition Objectives and Measures: Base Score Required Measures

Objective	Measure
Protect Patient Health Information	Security Risk Analysis
Electronic Prescribing	e-Prescribing
Patient Electronic Access	Provide Patient Access
Health Information Exchange	Health Information Exchange

Advancing Care Information – Flexibility

- CMS will automatically reweight the Advancing Care Information performance category to zero for:
  - Hospital-based MIPS clinicians,
  - clinicians with lack of Face-to-Face Patient Interaction,
  - NP,
  - PA,
  - CRNAs, and CNS
- Reporting is optional although if clinicians choose to report, they will be scored.
- Significant Hardship
  - If clinician is unable to report advancing care information measures, they can apply to have their performance category score weighted to zero

Improvement Activities – New Component

- Attestation of activities to improve clinical practice
- 9 Subcategories
  - More than 90 Activities
- Subcategories:
  - Expanded Practice Access
  - Population Management
  - Care Coordination
  - Beneficiary Engagement
  - Patient Safety and Practice Assessment

- Participation in APM
- Achieving Health Equity
- Integrating Behavioral and Mental Health
-Emergency Preparedness and Response

Improvement Activity Requirements Transition Year

Test Pace

- Submission of 1 improvement activity
- Activity can be high weight or medium weight

Partial and Full participation

- Reporting one of the following combinations:
  - 2 high-weighted activities o
  - 1 high-weighted activity and 2 medium-weighted activities
  - At least 4 medium-weighted activities

Improvement Activities - Flexibility

- Group – 15 or fewer participants, non-patient facing clinicians or Rural HPSA
  - Attest that you completed up to 2 activities for a minimum of 90 days
- Certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model
  - Automatically earn full credit
- Shared Savings Program Track 1 or the Oncology Care Model
  - Points automatically received based on APM participation
  - Current APMs under the APM scoring standard
    - Full credit
  - For all future APMs under the APM scoring standard,
    - At least half credit.

MIPS Performance Categories

- Cost
  - No reporting requirement
  - 0% 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 – No affect on 2019 payment

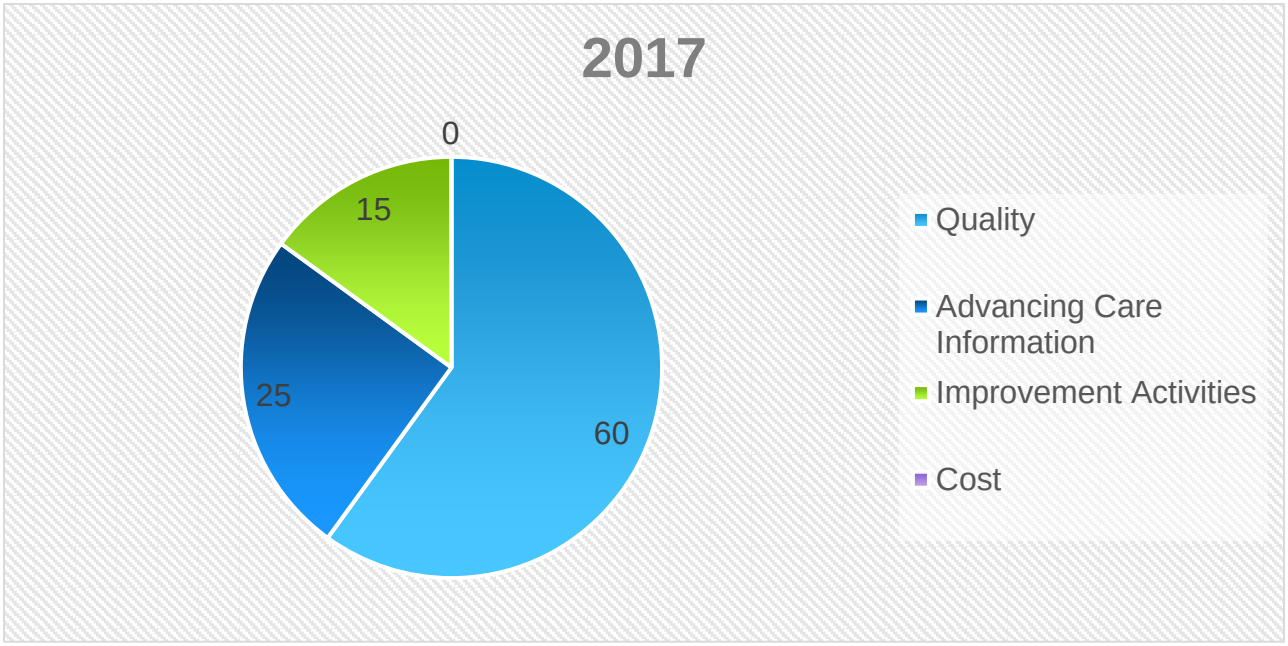
MIPS Performance Category - Cost

- Reporting
  - For the transition year, there are no requirements for the Cost Performance Category
    - Based on Value Based Modifier
      - Medicare Spending per Beneficiary
      - Total per-Capita Cost for all Attributed Beneficiaries
- Flexibilities
  - Cost reporting – No affect of 2019 payment
  - Clinicians' Cost performance is targeted to be included in the 2018 performance feedback to help assess performance and prepare for the second year of the program
  - Data Submission – no action on the part of the clinician

MIPS Scoring

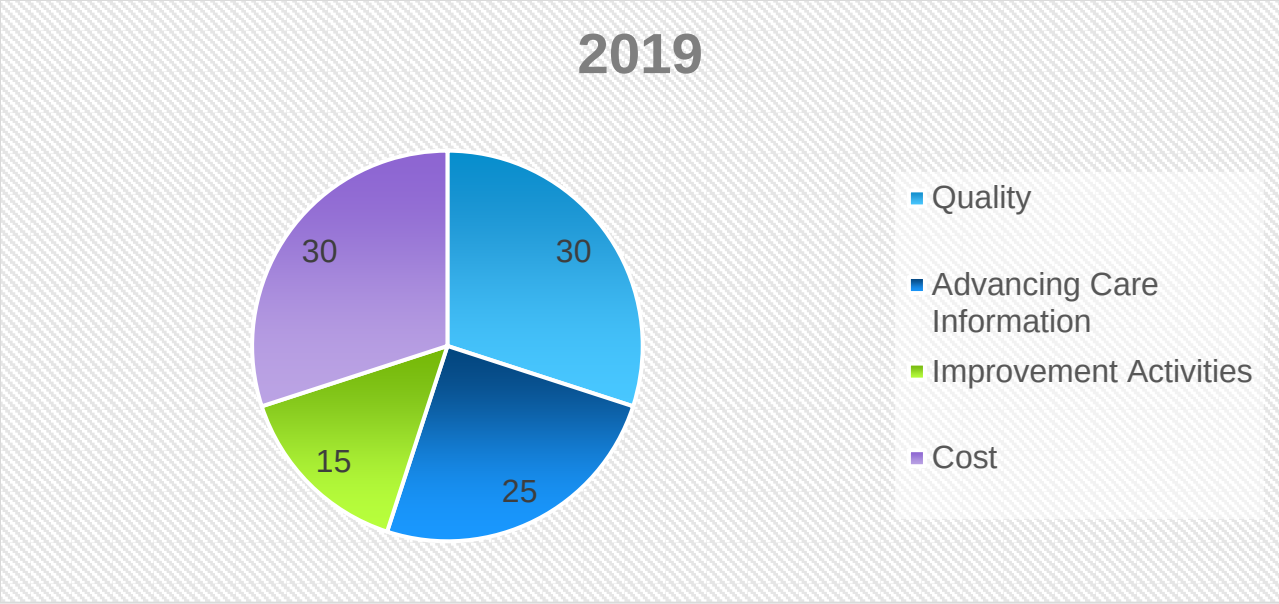
MIPS – Scoring in the Transition Year

- MIPS Component Weights



MIPS – Scoring for 2019

- MIPS Component Weights - 2019



MIPS Scoring

- Quality – 60 percent of the Final Score for the Transition Year
- Report 6 of the 300 (approximate) available quality measures (minimum of 90 days)
  - Or a specialty set
  - Or CMS Web Interface measures
  - Readmission measure is included for group reporting with groups with at least 16 clinicians and sufficient cases
- 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

MIPS Scoring

- Quality –
- If a measure can be reliably scored against a benchmark, then clinician can receive 3 – 10 points
  - Reliable score means the following:
    - Benchmarks exists
    - Sufficient case volume
    - Data completeness met
      - at least 50 percent of possible data is submitted
- If a measure cannot be reliably scored against a benchmark
  - Clinician receives 3 points

MIPS Scoring

- Quality – Bonus Points
  - Clinicians receive bonus points by:
    - Submitting an additional high priority measure
      - 2 bonus points for each additional outcome and patient experience measure
      - 1 bonus point for each additional high-priority measure
    - Using CEHRT to submit measures to registries or CMS
      - 1 bonus point for end-to-end electronic submission

MIPS Scoring

- Quality Total Quality Performance Category Score – 60 percent

Total Quality Performance Category Score

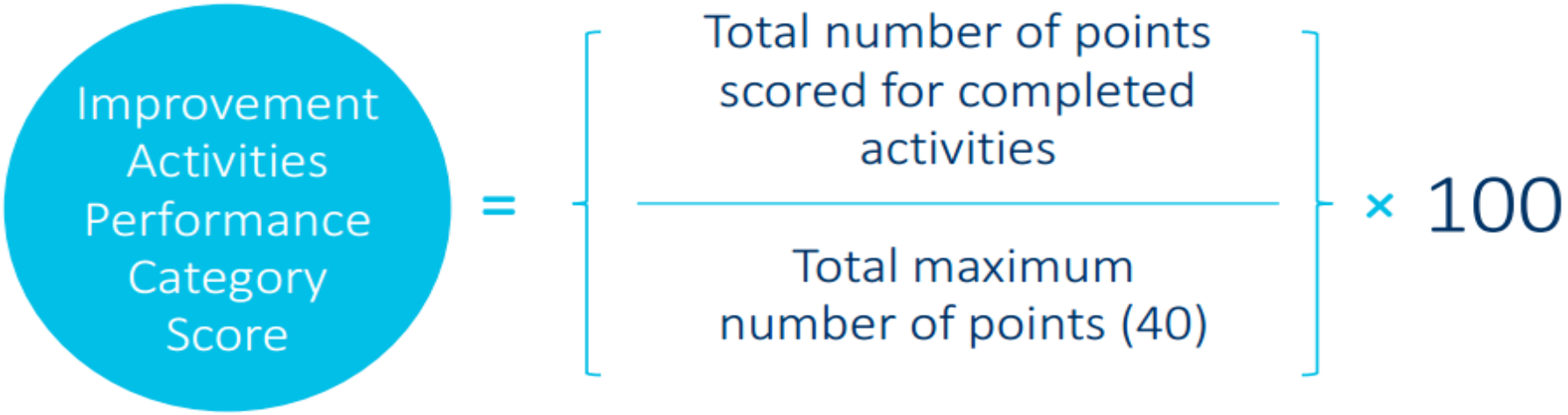
= Points of 6 quality measures + bonus points

MIPS Scoring

- Improvement Activities
  - Total points =40
  - Activity Weights
    - Medium = 10 points - High = 20 points
  - Alternate Activity Weights -
    - Medium = 20 points - High = 40 points
      - Applies to clinicians in small, rural, and underserved practices or with nonpatient facing clinicians or groups
  - Full credit for clinicians in a patient-centered medical home, Medical Home Model, or similar specialty practice

MIPS Scoring

- Improvement Activities – 15 percent



MIPS Scoring

Advancing Care Information – 25 percent

- Clinicians must submit a numerator/denominator or Yes/No response for each of the following required measures:

Advancing Care Information Measures	2017 Advancing Care Information Transition Measures
Security Risk Analysis e-Prescribing Provide Patient Access Send a Summary of Care Request/Accept a Summary of Care	Security Risk Analysis e-Prescribing Provide Patient Access Health Information Exchange

MIPS Scoring

Advancing Care Information Performance Score

- Report up to 9 Advancing Care Information measures OR
- Seven 2017 Advancing Care Information Transition Measures

- Each measure is worth 10-20%. The percentage score is based on the performance rate for each measure:

Performance Rate 1-10	1%
Performance Rate 11-20	2%
Performance Rate 21-30	3%
Performance Rate 31-40	4%
Performance Rate 41-50	5%
Performance Rate 51-60	6%
Performance Rate 61-70	7%
Performance Rate 71-80	8%
Performance Rate 81-90	9%
Performance Rate 91-100	10%

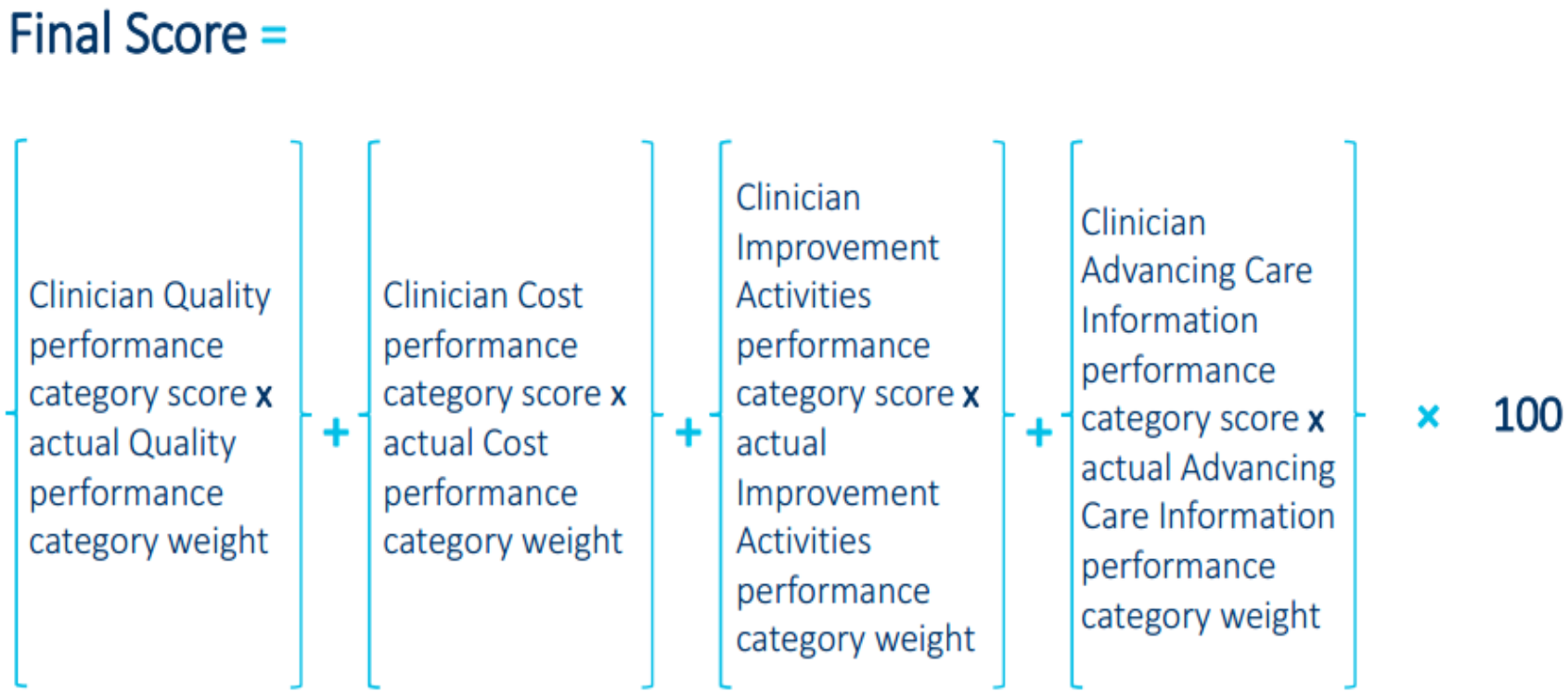
Advancing Care Information - Bonus Score

- Five percent bonus for reporting on any of these Public Health and Clinical Data Registry Reporting measures:
  - Syndromic Surveillance Reporting
  - Electronic Case Reporting
  - Public Health Registry Reporting
  - Clinical Data Registry Reporting
- Ten percent bonus for using CEHRT to report certain Improvement Activities

MIPS Scoring

Advancing Care Information - 25% of Final Score

Final Calculation Score



Alternate Payment Models

Alternative Payment Models (APMs)

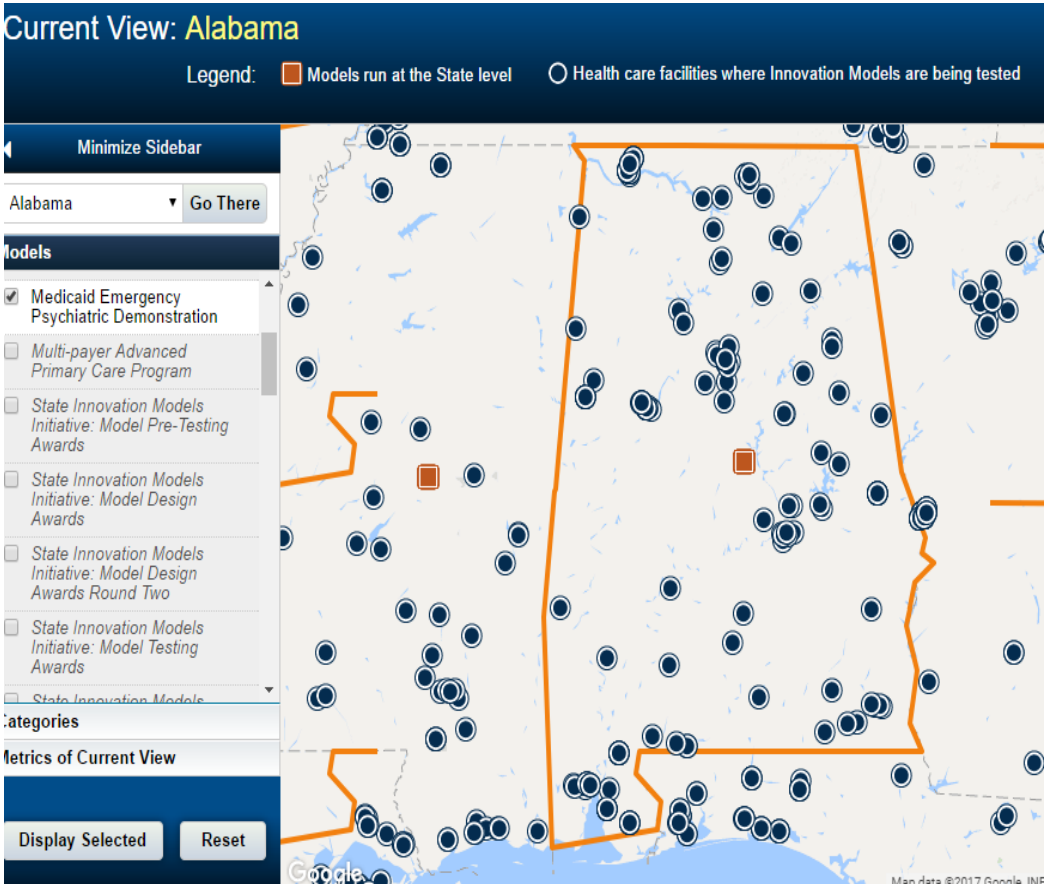
- An APM is a payment approach
  - Incentive payments provided for to high-quality and cost-efficient care
  - Applicable to specific clinical conditions, a care episodes, or a population
- Advanced APMs
  - Subset of APMs
  - Higher reward potential
  - Shared Risk – related to patient outcomes
  - 5 percent incentive payment in improving patient care and taking on risk through an Advanced APM
- Participation
  - Apply with an Advanced APM that fits the provider practice
  - Advanced APMs must be currently accepting applications
- Benefits of an Advanced APM
  - Receive a 5% incentive payment in 2019 for Advanced APM participation in 2017 if:
    - 25 percent of the provider's Medicare Part B payments are received through an Advanced APM
    - 20 percent of the provider's Medicare patients are seen through an Advanced APM

Alternative Payment Models (APMs)

- APMs and Advanced APMs
  - Located at: https://innovation.cms.gov/initiatives/index.html#views=models
  - Choose appropriate state
  - Models listed by geographic location
  - Indicate models run at a State level
  - Innovation Models being Tested

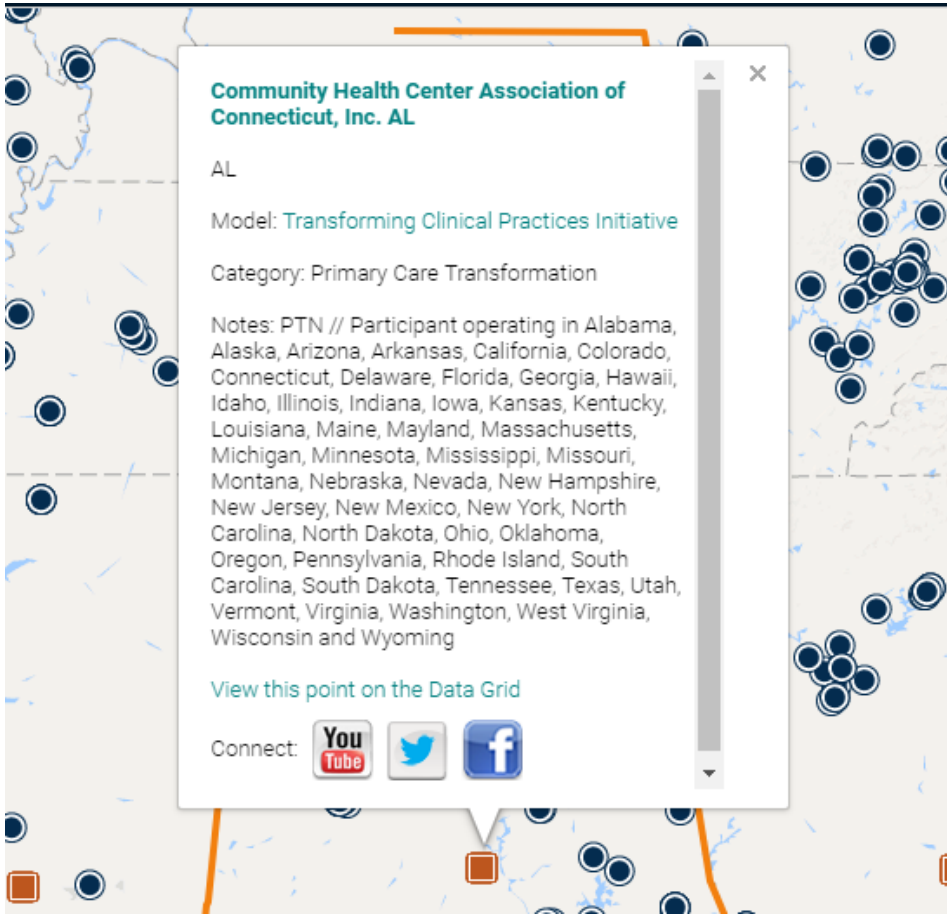
APMs – State Example

- Alabama



APMs – State Example

- Alabama



Innovation Models in Testing

- Alabama

Health care facilities where Innovation Models are being tested

View 5 ▾ Search:

Model Name	Organization Name	Address	City	State	Notes
Acute Myocardial Infarction (AMI) Model	D C H Rehabilitation Pavilion Tuscaloosa, AL	1101 Sixth Ave East	Tuscaloosa	AL	MSA: Tuscaloosa, AL
Acute Myocardial Infarction (AMI) Model	Hale County Hospital Greensboro, AL	508 Green Street	Greensboro	AL	MSA: Tuscaloosa, AL
Acute Myocardial Infarction (AMI) Model	North Baldwin Infirmary Bay Minette, AL	1815 Hand Avenue	Bay Minette	AL	MSA: Daphne-Fairhope-Foley, AL
Acute Myocardial Infarction (AMI) Model	Northport Medical Center Northport, AL	2700 Hospital Drive	Northport	AL	MSA: Tuscaloosa, AL
Acute Myocardial Infarction (AMI) Model	South Baldwin Regional Medical Center Foley, AL	1613 North Mckenzie Street	Foley	AL	MSA: Daphne-Fairhope-Foley, AL

APMs – State Example

- Alabama

Acute Myocardial Infarction (AMI) Model

Share

On December 20, 2016, the Centers for Medicare & Medicaid Services (CMS) finalized regulations regarding the Acute Myocardial Infarction (AMI) Model in the Advancing Care Coordination through Episode Payment Models final rule.

This final rule implements a new payment model for Part A and B items and services provided to Medicare fee-for-service beneficiaries undergoing hospitalization for AMI. The Model is being implemented under section 1115A of the Social Security Act. The Model furthers CMS' goal of improving the efficiency and quality of care for Medicare beneficiaries with AMI, a common and serious condition, and encourages hospitals, physicians, and post-acute care providers to work together to improve the coordination of care from the initial hospitalization through recovery.

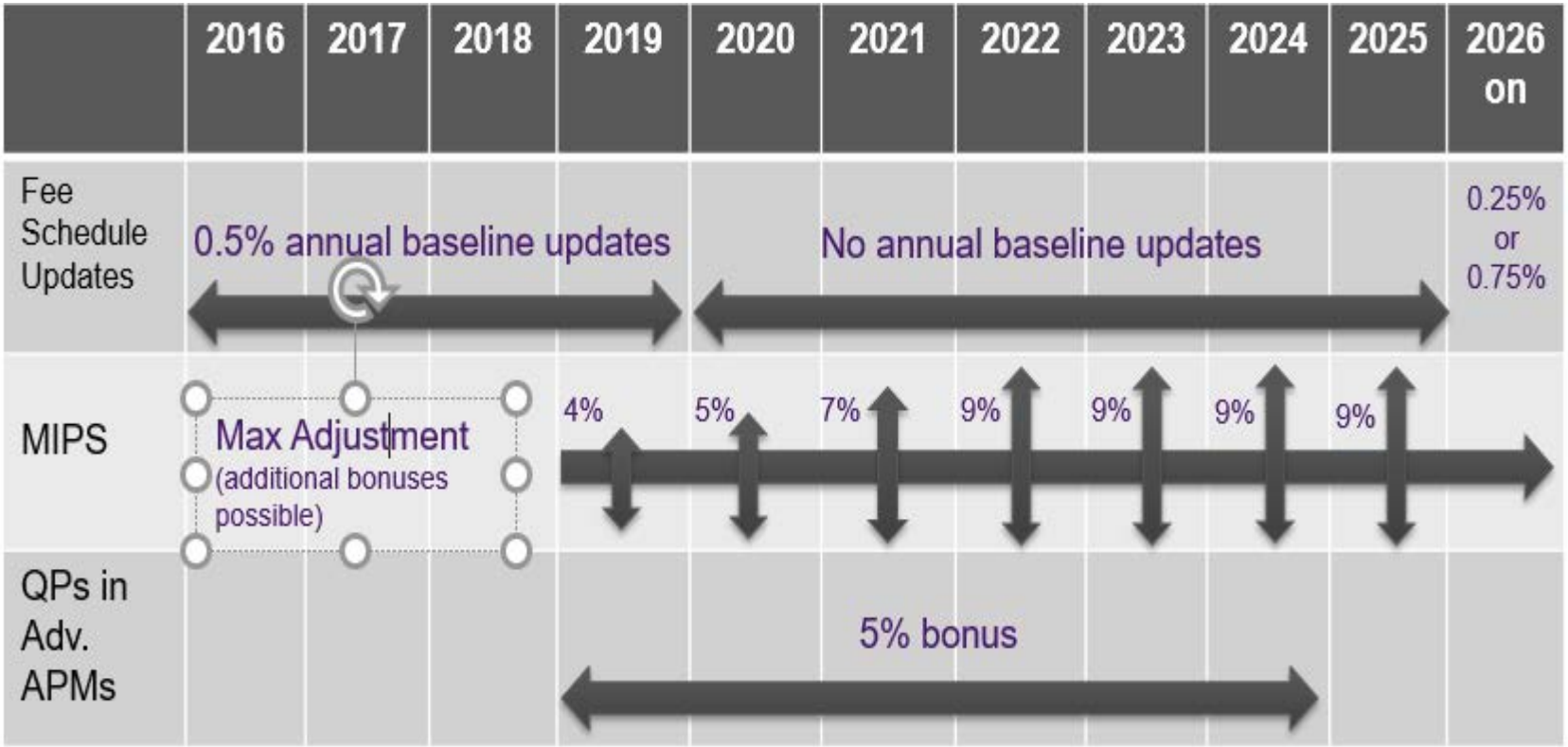
Background

Acute care hospitals in certain selected geographic areas will participate in retrospective bundled payments for items and services that are related to AMI treatment and recovery, beginning with a hospitalization for AMI treatment and extending for 90 days following hospital discharge. Under the AMI Model, the hospital is financially accountable for the quality and cost of an AMI episode of care, which incentivizes increased coordination of care among hospitals, physicians, and post-acute care providers. An AMI episode is defined by the admission of an eligible Medicare fee-for-service beneficiary to a hospital paid under the Inpatient Prospective Payment System (IPPS) that eventually results in a discharge paid under the following Medicare Severity-Disease Related Group (MS-DRG):

- MS-DRG 280 (Acute myocardial infarction, discharged alive with MCC),
- MS-DRG 281 (Acute myocardial infarction, discharged alive with CC),
- MS-DRG 282 (Acute myocardial infarction, discharged alive without CC/MCC).

https://innovation.cms.gov/initiatives/ami-model/

Timelines and Payment Adjustments



Timelines and Payment Adjustments

2017	Jan 1: First transitional performance period begins
	Spring: PQRS, VBM, MU pay adjustments (2015 performance)
	Oct 1: Last chance to start 90-day reporting period
	Nov 1: 2018 performance threshold announced
	Dec: Notification of LVT exception (9/1/16-8/31/17)
2018	Jan 1: Second transitional performance period begins
	Jan 2-Mar 31: Submission period for 2017 performance data
	Spring: Final PQRS, VBM, MU pay adjustments (2016 performance)
	Nov 1: 2019 performance threshold announced
	Dec: Notification of LVT exception (9/1/17-8/31/18)
2019	Jan 1: QPP transitional reporting completed
	Spring: First QPP pay adjustments implemented (2017 performance)

MACRA Checklist

- Are you exempt from MIPS?
  - Low volume provider?
  - Qualified participant in an advanced APM?
- How will you participate? Group or Provider
- Small, rural, non-patient-facing accommodations?
- Participation in a qualified clinical data registry?
- Review of PQRS and QRUR? Identified Areas of Improvement
- Current engagement of Improvement Activities? What areas would you participate ?
- Certified EHR?
  - 2014 or 2015 edition?
  - Vendor support Medicare quality reporting?

Source Authorities

- Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician, -Focused Payment Models <81 CFR 77008>

- "The Medicare Access and Chip Reauthorization Act of 2015 – Path to Value", CMS
- Quality Payment Program Home Page, CMS, https://qpp.cms.gov/learn/qpp
- "Flexibility and Support for Small Practices", CMS Fact Sheet
- CMS Innovation Center, https://innovation.cms.gov/initiatives/ami-model/