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MACRA
Quality Payment Programs - 2019

MACRA

Enacted on April 16, 2015 - Effective January 1, 2017

Repeal of the SGR formula for determining Medicare Physician Fee Schedule payments.

Two quality payment program tracks to reward quality: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APM)

- APMs, MIPS APMs, Advanced APMs, All-Payer Advanced APMs

MACRA - MIPS Pillars

A single, unified goal of quality improvement.

MACRA four pillars of MIPS incentive structure
(1)quality;
(2)clinical practice improvement activities (referred to as "improvement activities");
(3) meaningful use of CEHRT (once referred to as "advancing care information" now "promoting interoperability"); and
(4) resource use (referred to as "cost").

MACRA – MIPS 3rd Year

- Continue to implement as required
- Updates in 2019 for the purpose of "reducing clinician burden"
  - Promoting advances in interoperability;
  - Meaningful Measures Initiative (more detail later); and
  - Establishing an automatic extreme and uncontrollable circumstances policy (more detail later)

Promoting Advances in Interoperability

Goals – making it easier for:

- Patients to access their data.
- Patient information to be shared between doctors and other health care providers.

MIPS eligible clinicians must use 2015 Edition certified EHR technology beginning with the 2019 MIPS performance period

Newly Added Eligible Clinicians – Facility Based Questions

Treated same as all Eligible Clinicians with respect to whether they are a facility-based individual or group (more detail below), however with respect to newly added eligible clinicians (such as physical and occupational therapists):

Facility-based outpatient therapy and skilled nursing facility claims do not contain the rendering NPI and usually contain just a facility NPI; **therefore, facility-based outpatient therapy and skilled nursing facility claims will not be eligible for MIPS.**

New Opioid Treatment-Related Measures

Reporting required in 2020 (optional for 2019):
Query of Prescription Drug Monitoring Program (PDMP) measure:
For at least one Schedule II opioid electronically prescribed using CEHRT during the performance period, the MIPS eligible clinician uses data from CEHRT to conduct a query of a PDMP for prescription drug history, except where prohibited and in accordance with applicable law.

Addition of the Verify Opioid Treatment Agreement measure:
For at least one unique patient for whom a Schedule II opioid was electronically prescribed by the MIPS eligible clinician using CEHRT during the performance period, if the total duration of the patient's Schedule II opioid prescriptions is at least 30 cumulative days within a 6-month look-back period, the MIPS eligible clinician seeks to identify the existence of a signed opioid treatment agreement and incorporates it into the patient's electronic health record using CEHRT.

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Brief Recap on Mechanics of MIPS

Ways to Measure and Pay

- CMS is scoring clinicians and groups on their performance in four categories: Quality, Cost, Improvement Activities (IA), and Promoting Interoperability (PI). (More on this in a few minutes)
- Starting in 2019, physicians in the MIPS track are facing a range of payment adjustments, from potential penalties of -4% to bonuses up to 12%. These penalties and bonuses will continue to increase, eventually exposing clinicians to decreases as much as 9% and increases of up to 27%.

Who Must Participate in MIPS?

- Any services billed under the Medicare Physician Fee Schedule (MPFS) will be impacted.
- Medicare Part B clinicians billing more $90,000 a year or providing care for more than 200 Medicare patients a year.

- CMS estimates 934,000 providers will be exempt from MIPS reporting.

Who is excluded from MIPS?

- Newly-enrolled Medicare clinicians:
  - Clinicians who enroll in Medicare for the first time during a performance period are exempt from reporting on measures and activities for MIPS until the following performance year.
- Clinicians below the low-volume threshold:
  - Medicare Part B allowed charges less than or equal to $90,000 **OR** 200 or fewer Medicare Part B patients.
- Clinicians significantly participating in Advanced APMs.

What About Other Medicare Payment Systems ?

MIPS only applies to Medicare Physician Fee Schedule. The following are excluded:

- Inpatient Prospective Payment System.
- Outpatient Prospective Payment System.
- Ambulatory Surgical Center Payment System.

Timeline for Implementation

- Clinician payments started to be adjusted on January 1, 2019.
- Minimal impact due to low thresholds in 2017. MIPS threshold in 2017 was on 3 points.
- CMS will use last year (2018) as the performance year for determining clinician payment adjustments in 2020. The minimum threshold in 2018 was 15 points.
- 2019 the minimum threshold will be 30 points.

(more latter on how the points work)

How is the Final MPS Score Determined?

How do MIPS Score and Payments Work?

CMS will translate a clinician's/group's performance score into a payment adjustment using the following three-step process:

1. Clinicians/groups/APM entities will be assigned a performance score of 0-100.
2. That score will be compared to the performance threshold (PT). (15 for 2018) Starting in 2022, the PT will either be the mean or the median—as selected by CMS—of the composite performance scores for all MIPS participants.
3. Clinicians/groups/APM entities that fall above the PT will receive bonuses, whereas clinicians that fall below the PT will face penalties.

So How Do Payment the 4 Categories Work?

- For each performance year, CMS sets a performance threshold (PT) number of points at which a provider earning PT points receives 0% Adjustment to their Medicare Part B payments – no penalty, no incentive. 2019 this number is 30 points.
- Annual MIPS score of up to 100 points is determined by 4 categories of clinician performance and bonus point opportunities. For the 2018 performance year, (2020 payment year):
  - Quality (45% weight, or 45 MIPS points maximum)
  - Cost (10% weight, or 10 MIPS points maximum)
  - Promoting Interoperability (25% weight, or 25 MIPS points maximum)
  - Improvement Activities (IA) (15% weight, or 15 MIPS points maximum)
  - Small Practice Bonus – less than 15 providers (6 MIPS points and included in quality); and
  - Complex Patient Bonus (5 MIPS points maximum).

Example of Calculating a MIPS Score

[A] PERFORMANCE CATEGORY	[B] PERFORMANCE SCORE	[C] CATEGORY WEIGHT	[D] EARNED POINTS ([B]*[C]*100)
Quality	75%	50%	37.5
Cost	50%	10%	5
Improvement Activities	40 out of 40 points 100%	15%	15
Advancing Care Information	100%	25%	25
Subtotal (Before Bonuses)			82.5
Complex Patient Bonus			3
Small Practice Bonus			0
Final Score (not to exceed 100)			85.5

Quality

- There are approximately 300 MIPS quality measures, but applicable measures vary by group type. Depending upon the reporting method, different quality measures are available and required.
- Each measure earns "measure achievement points". Under a given reporting method, there is a total possible number of measure achievement points, termed the "total available measure achievement points". Each measure can earn up to 10 measure achievement points.
- The "achievement percent score" is the total measure achievement points earned across the required number of measures divided by the total available measure achievement points. E.g. if a clinician reports 6 measures using the EHR reporting method and earns 7 out of 10 measure achievement points for each measure, then the achievement percent score would be: (6 measures x 7 points) / (6*10) = 42 / 60 = 70%.

Costs

- No data submission required, calculated from adjudicated claims.
- Each measure earns up to 10 measure achievement points via a peer-percentile benchmark scale based on measure performance rate.
- E.g. Total available measure achievement points are equal to 2 measures x 10 points = 20 points.
- Due to BAA of 2018, CMS does not have to move the Cost category weight to 30% until 2022. However, during the years 2019-2021, CMS may choose any Cost category weight between 10% to 30%. In 2019 this was increased by 5%

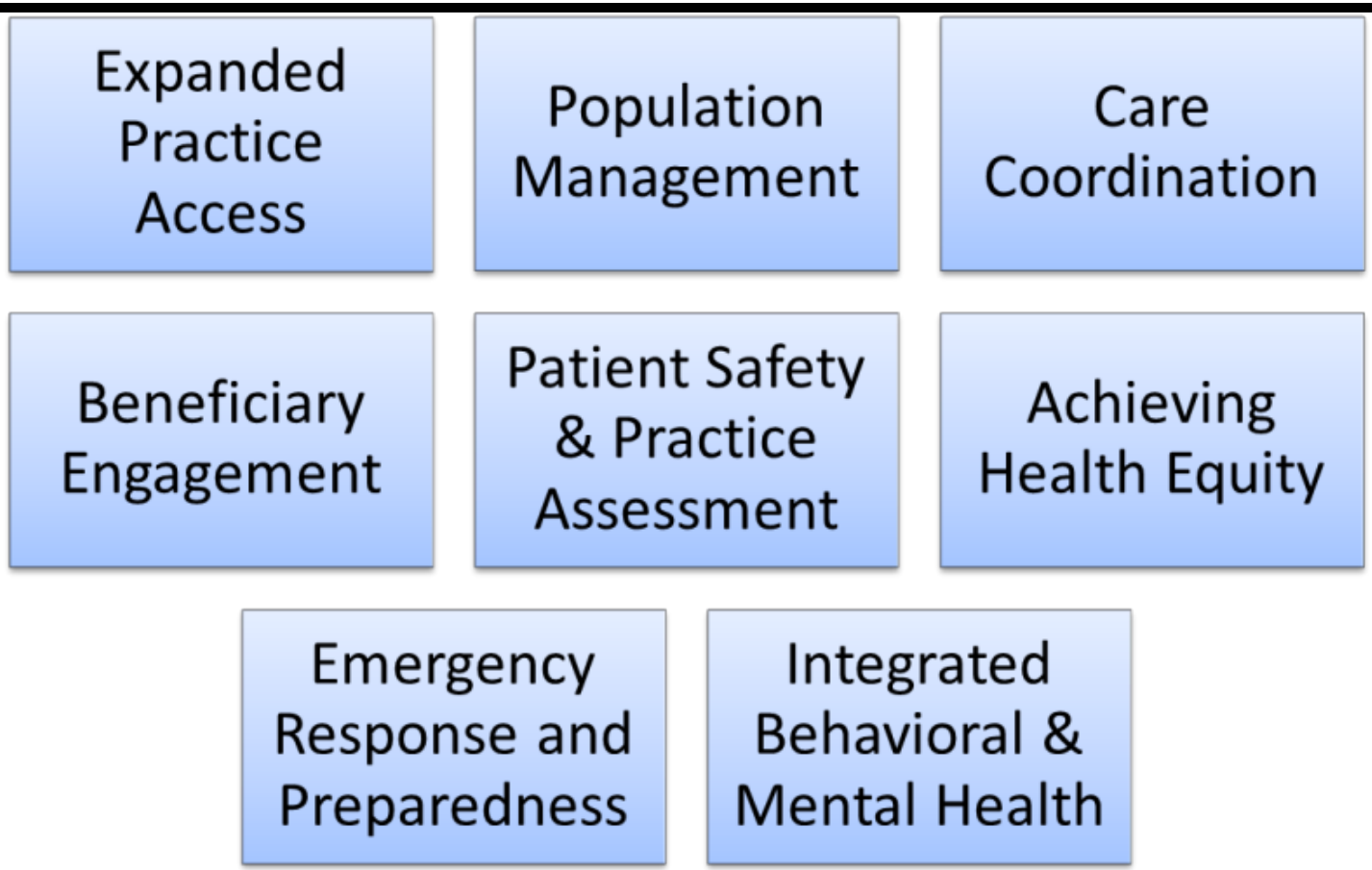
Promoting Interoperability

- Formally known as Advancing Care Information
- Completely overhauled for 2019!!!
- Will discuss Changes in a few minutes

Improvement Activities (IA)

- The MIPS IA category gauges the extent to which a clinician or group of clinicians is engaged in activities to improve clinical practice or care delivery.
- Clinicians in small practices (15 or fewer clinicians), practices located in rural areas or geographic HPSAs, or non-patient facing clinicians must earn at least 20 activity points.
- All other clinicians or clinician groups must earn at least 40 activity points to earn the maximum possible IA score.

Improvement Activities categories



MIPS Financial Impact Range

PERFORMANCE YEAR	MEDICARE PART B PAYMENT ADJUSTMENT YEAR	MAXIMUM -% MIPS PENALTY	MAXIMUM +% MIPS BASE INCENTIVE	MAXIMUM +% MIPS EXCEPTIONAL PERFORMANCE BONUS
2017	2019	-4%	+4%*X (CMS predicts 0.86%)	+10%*Y (CMS predicts 1.52%)
2018	2020	-5%	+5%*X (CMS predicts 0.30%)	+10%*Y (CMS predicts 1.75%)
2019	2021	-7%	+7%*X	+10%*Y
2020	2022	-9%	+9%*X	+10%*Y
2021	2023	-9%	+9%*X	+10%*Y
2022	2024	-9%	+9%*X	+10%*Y

CMS calculates "budget-neutrality factor" (**"X"**) so that incentive pool equals penalty dollars assessed. In 2018 this was $390M

"Y" is calculated by allocating $500M per year (available each year through 2022) to an exceptional performance bonus pool for high performers based on scoring rules.

Reporting All of this Data…

- For each performance year, a provider organization may choose to report MIPS data for clinicians individually, or as a group billing through a common TIN.
- Decision must apply equally across all MIPS categories for a given performance year.
- A clinician cannot choose to be subject as an individual in some categories while relying on a group for other categories.

Reporting - Individual

- If you send MIPS data in as an individual, your payment adjustment will be based on your performance.
- An individual is defined as a single National Provider Identifier (NPI) tied to a single Tax Identification Number.
- You'll send your individual data for each of the MIPS categories through a certified electronic health record, registry, or a qualified clinical data registry. You may also send in quality data through your routine Medicare claims process.

Reporting - Group

- If you send your MIPS data with a group, the group will get one payment adjustment based on the group's performance.
- A group is defined as a set of clinicians (identified by their NPIs) sharing a common Tax Identification Number, no matter the specialty or practice site.
- Each TIN receives a single MIPS score, and every clinician billing Part B through that TIN inherits the group's MIPS score.
- Your group will send in group-level data for each of the MIPS categories through the CMS web interface or a third-party data-submission service such as a certified electronic health record, registry, or a qualified clinical data registry.

Group Reporting - Virtual Group

- Practices each with up to 10 clinicians may together form a "virtual group" for the purpose of earning and submitting data for a collective MIPS score.
- The vast majority of MIPS group scoring rules apply to virtual groups.

How Do You Report?

Performance Category	Submission Mechanisms for Individuals	Submission Mechanisms for Groups (Including Virtual Groups)
 Quality	QCDR Qualified Registry EHR Claims	QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
 Cost	Administrative claims (no submission required)	Administrative claims (no submission required)
 Improvement Activities	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
 Advancing Care Information	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)

Changing Groups During a Performance Year

- If you bill Medicare Part B charges under more than one group (TIN) during the performance period, you are required to participate in MIPS for each TIN association except in cases where those TINs are excluded under MIPS.
- If you start working for a new practice or create a new TIN that did not previously exist during the performance period, CMS will use the final score for the old practice to apply the MIPS payment adjustment for the NPI in the new practice.
- in MIPS as a group.

Changing Groups During a Performance Year

- If you are billed under more than one TIN during the performance period, and start working in a new practice or create a new TIN, CMS will take the highest final score associated with your NPI in the performance year.
- If a practice hires a clinician, his/her payments would continue to be adjusted based on his/her actual performance during the performance period, even if under a different TIN. The clinician would not simply adopt the new practice's payment adjustment during the payment year, even if that new practice participates

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MIPS Changes for 2019

Updates For 2019

- For the 2019 MIPS performance year final score, the weights will be:
  - **Quality**, decreased by 5% to 45% of total weight;
  - **Cost** increased by 5 % to 15% of the total weight for 2021 payment year;
  - **Improvement activities**, 15 percent (Remains the Same)
  - **Promoting Interoperability**, 25 percent. (Remains the Same)
- MIPS performance threshold raised to 15 points in year 2 (from 3 points in the 2017).

Updated From 2018 MACRA QPP Final Rule

- Adjustment rise to 7% increase and decrease.
- “Exceptional Performance Bonus threshold increased from 70 points to 75 points.
- Low volume providers may now opt in to MIPS

Quality Measures Updated

- CMS is struggling to keep these measures meaningful.
- Many measure are being “topped out.” A topped-out measure is defined as one in which average scores are so high that it’s difficult for CMS to meaningfully rank providers.
- CMS is moving towards outcome-based measures and away from process-based and topped-out measures. Removing topped-out measures will reduce the points many clinicians earn for Quality, but it fits with CMS’ goal of making MIPS more challenging.

Quality Measures Updated

- For 2019, CMS removed 26 MIPS quality measures. These included:
  - Dermatology – 224: Melanoma Overutilization of Imaging Studies
  - Ophthalmology – 140: Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement
  - Gastroenterology – NQF068: Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet
  - Otolaryngology – 276: Sleep Apnea – Assessment of Sleep Symptoms
  - Otolaryngology – 278: Sleep Apnea – Positive Airway Pressure Therapy Prescribed
  - Otolaryngology – 334: Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse)

Quality Measures Updated

- Eight new quality measures were added,
- Claims-based measures will only be allowed for clinicians in small practices (15 or fewer clinicians).

Promoting Interoperability

- This measure was significantly revised.

- i.e. CMS threw it out and started over.

Promoting Interoperability

- CMS has added four new measures, including
  - Query of Prescription Drug Monitoring Program (PDMP) and
  - Verify Opioid Treatment Agreement.
- Measures non consist of the following objectives:
  - e-Prescribing,
  - Health Information Exchange,
  - Provider to Patient Exchange, and
  - Public Health and Clinical Data Exchange.
- Unless an eligible clinician or group is able to claim an exclusion, they must report certain measures from each objective.

Episode-based Cost measures

CMS also added eight episode-based measures, which may affect orthopedic surgeons, gastroenterologists and ophthalmologists:

- Elective Outpatient Percutaneous Coronary Intervention (PCI) (Procedural)
- Knee Arthroplasty (Procedural)
- Revascularization for Lower Extremity Chronic Critical Limb Ischemia (Procedural)
- Routine Cataract Removal with Intraocular Lens (IOL) Implantation (Procedural)
- Screening/Surveillance Colonoscopy (Procedural)
- Intracranial Hemorrhage or Cerebral Infarction (Acute inpatient medical condition)
- Simple Pneumonia with Hospitalization (Acute inpatient medical condition)
- ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI) (Acute inpatient medical condition)

2015 CEHRT required

- For 2019, 2015 CEHRT is mandatory for reporting EHR measures.
- Most providers are already using 2015 CEHRT, so this will not be an issue.

What Must a Clinician Do Now?

- During 2019, Physicians need not select the track that they will be on in 2019 or 2020, but they need to plan on where they will likely end up.
- Plan for payment adjustments in 2019 and 2020 based on performance this year and last year.

Performance Measurements

- MIPS payment track will be scored based on Clinician's performance across four categories:
  - Quality
  - Cost
  - Improvement Activities
  - Advancing Care Information

Reputational Harm

- CMS began publishing clinician-identifiable performance measures through its Physician Compare website.
- The a 5-star rating scale will be applied to every MIPS performance measure for purpose of peer comparisons.

Legacy Financial Impact

- The financial and reputational impacts stemming from the MIPS score are irrevocably attached to a clinician, even if the clinician changes organizations.
- If a clinician earns a MIPS score for 2019 and moves to another organization in 2020, the new organization will inherit the MIPS payment adjustment applied in 2020 based on the 2018 score earned by the clinician at the previous organization.
- MIPS scoring needs to be integrated into a practices recruitment and candidate assessment process.

Legal Considerations

- Implications on Employment and Independent Contactor Agreements.
- Fraud and Abuse Enforcement.

MACRA Compliance Risk Areas

- Integrity of clinical quality data (unchanged from original source)
- Accurate clinical documentation to support quality measures (False Claims Act)
- Remaining current with rules – evolving and complex
- EMR platform functionality required to document, capture and report quality measures
- Misuse of EMR: Cloned note and Copy/Paste
- Use of Scribes
- Under-utilization – Gainsharing rules

Audit

- MIPS is auditable by CMS for up to 6 years after the associated data submission.
- Annually, CMS will selectively audit clinicians and groups and require them to share primary source documents, such as patient medical records, within 45 days of request.

Questions Providers Should Be Asking

- Are you exempt from MIPS?
  - Low volume provider?
  - Qualified participant in an advanced APM?
- Do you want to participate as an individual or as a group?
- Do you meet requirements for small, rural, non-patient-facing accommodations?
- Do you/can you participate in a qualified clinical data registry?
- Do your PQRS and QRUR reports reveal areas for improvement?
- Which Improvement Activities are you engaged in now?
- What are you interested in doing?

Tips For Success

Increased competition among clinicians to achieve high MIPS scores as measure benchmarks and score thresholds rise will continue to raise the financial and reputational stakes.

- Educating leaders and all physicians about the evolution of MIPS.
- Establishing a continuous performance improvement discipline and process perhaps catalyzed by MIPS.
- Estimating current MIPS baseline performance ahead of the 2017 MIPS feedback report (released by CMS in fall 2018).

Tips For Success

- Identify organizational gaps and model changes.
- Analyze MIPS cost category performance and improvement through analyzing existing data sources, such as CMS, QRUR reports and internal claims data.
- At least annually revisiting past MIPS program decisions.
- Re-evaluate how resources are allocated and the structure of the organization to optimize MIPS.
- Create a multi-year plan including MIPS and APMs.

MACRA Compliance Strategies

- Know which track providers are on and understand the rules
- Provide MIPS and/or APM education for providers and staff
- Ensure providers, coders and staff understand requirements for selected quality measures
- Update compliance plan to include monitoring and validation of quality measures
- Conduct a risk assessment to understand and evaluate how quality data is collected and reported
- Ensure compliance has a seat on the quality committee/team

CMS Primary Cares Initiative

- Announced on April 22
- New set of payment models
- Primary care practices and other providers will have 5 new payment model options under 2 paths (Primary Care First and Direct Contracting)

CMS Primary Cares Initiative (cont.)

PCF:

- payment to practices through a simplified total monthly payment
- Includes a payment model option that provides higher payments to practices that specialize in care for high need patients, including those with complex, chronic needs and seriously ill populations.
- Incentivize providers to reduce hospital utilization and total cost of care.
- Scheduled to begin January 2020

CMS Primary Cares Initiative (cont.)

DC payment model options

- aim to engage larger organizations that have experience taking on financial risk and serving larger patient populations, such as Health Systems, ACOs, MA Pans and Medicaid managed care organizations.
- Range of financial risk options, including Fixed monthly payment that can range from a portion of anticipated primary care costs to the total cost of care, some may bear full financial risk and others will share risk with CMS. Also, a geographic option that would allow provider to assume risk for the total cost of primary care for certain communities in a region.
- Expected to launch January, 2021

Questions and Answers?

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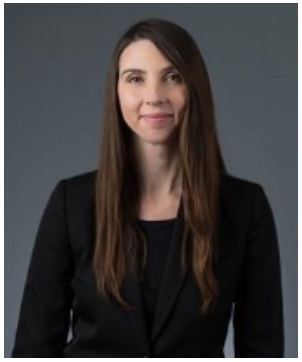

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