Medicare's New Payment System for Medical Practices

Understanding MACRA

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Another acronym…

Medicare	**M**edicare
Access &	**A**nalytics &
Chip	**C**onvoluted
Reauthorization	**R**eimbursement
Act of 2015	**A**ct of 2015

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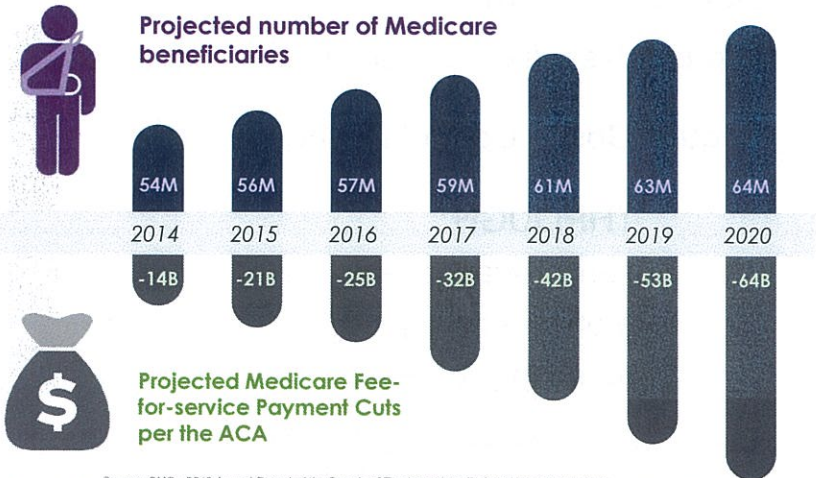

Source: CMS. "2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds." May 31, 2013, available at: http://downloads.cms.gov/files/TR2013.pdf

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Medicare Payment Prior to MACRA

Sustainable Growth Rate (SGR):

* 1997 - control the cost of Medicare payments to physicians

Each year, Congress passed temporary 'doc fixes' to avert cuts (21% scheduled for 2015)

Defining Value

Improve Results – Better Clinical Outcomes

Reduce Cost – Control Resource Use

THROUGH

Patient Engagement

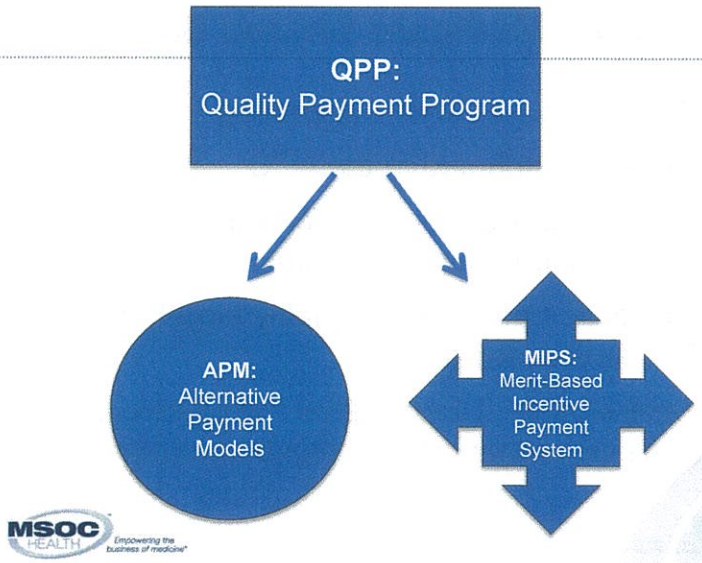
Use of Technology

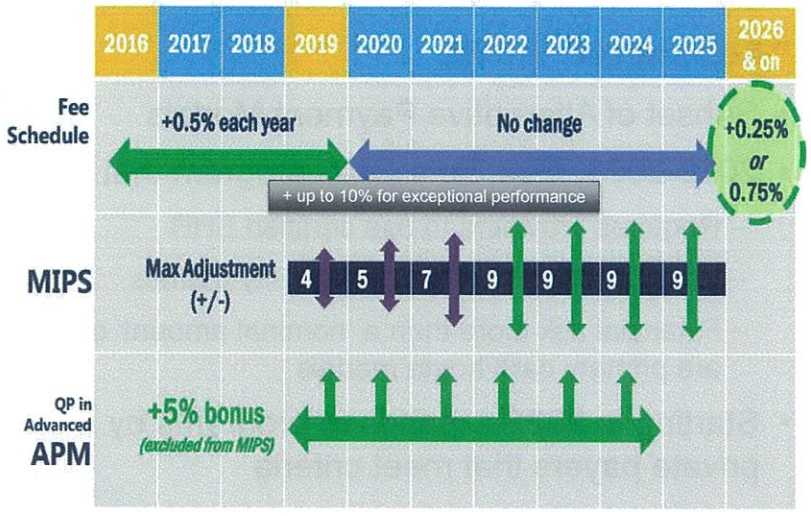
Process Improvement

CMS Goal: By 2018, 80% of Medicare payments tied to value and quality

Timeline

- MACRA Legislation – April 2015
  - 0.5% increase 7/2015, 0.5% Jan 1 2016-2019
  - Pay for Volume → Pay for Value
- Proposed Rule – April 27, 2016
  - 60 day comment period ends June 27, 2016
  - Expect Final Rule November 1
- First Payment Year: 2019
- First Reporting Period – 12 Months starting Jan 1, 2017





The APM Pathway:

Qualifying Provider in an Alternative Payment Model

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APM

ACO – Medicare Shared Savings

- ACO Entity applies and is approved
- Patients are attributed to the ACO
- Total annual costs projected for attributed patients based on historical data
- Actual costs < projected & quality targets met ➔ ACO shares in savings
- In Some Models - Actual costs > projected, ACO receives lower than normal reimbursement

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"Advanced" APM:

- Subset of Alternative Payment Models
- 2019-2020, must be a CMS program that:
  - Requires providers to use certified EHR
  - Bases provider payment on quality metrics
  - Financial risk more than a 'nominal amount' or are primary care home models
- Starting in 2021 expands to programs by private payers that meet criteria

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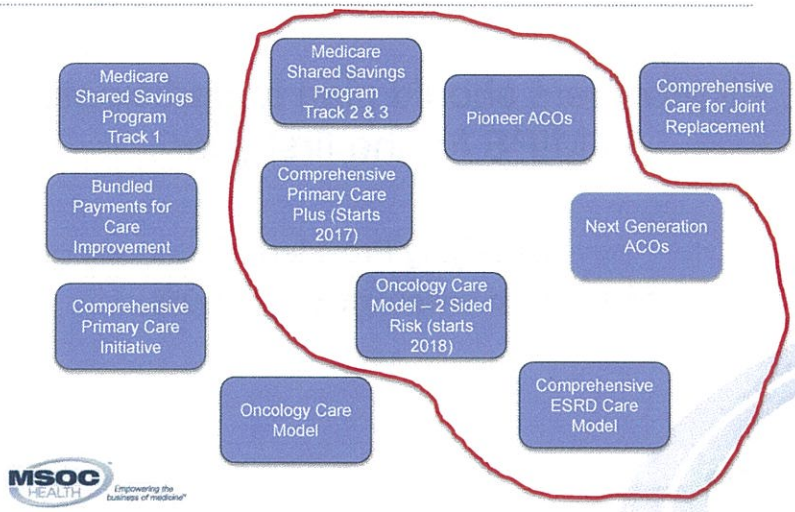
Proposed: APM vs Advanced APM



Qualifying Provider

- Listed participant in Advanced APM
- Meets Threshold Volume in Advanced APM
  - 2017: 25% of Medicare allowables OR patients
  - QPs identified after end of reporting year
- Future Years: 50-75% and may include non-Medicare APMs

MACRA Payments under APM Path

- APM Entity paid by CMS based on individual program rules
- QP Bonus Payment
  - 5% of payment year allowables
  - Lump Sum payment
  - Paid after end of payment year
- After 2026, standard payment rates increase 0.75% per year for QP; 0.25% for others

Key Point

All providers should plan to participate in MIPS for the first year

Qualifying Providers
determined based on 2017 results

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The MIPS Pathway:
Merit-Based Incentive Payment System

Combining MU, PQRS and VBM

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MIPS: Changing the Payment Model

File a Claim

Each service identified by a CPT Code

Each CPT has a fee set annually based on RVU and a Conversion Factor

CMS pays 80% of the allowable fee for the CPT shown on the claim

CMS passes claim to supplemental plan or patient pays remaining 20%

File a Claim

Each service identified by a CPT Code

Each CPT has a fee set annually based on RVU and a Conversion Factor

Each provider has a payment adjustment factor applied to allowable fee for each CPT

CMS pays 80% of the ADJUSTED allowable fee

CMS passes claim to supplemental plan or patient pays remaining 20%

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MIPS Overview

- Replaces MU, PQRS, VBM
- Pay for Performance

Reporting Year	Payment Year	Maximum Reduction	Maximum Increase
2017	2019	-4%	+12%
2018	2020	-5%	+15%
2019	2021	-7%	+21%
2020+	2022+	-9%	+27%

  - Budget Neutral
  - Additional $500 Million/year to top performers

Eligible Clinician

- Physician, PA, NP, CNS, CRNA
- Exceptions:
  - Low volume: < $10,000 in Medicare allowables AND < 100 Medicare patients
  - First year billing to Medicare (any TIN)
  - Qualifying Provider in Advanced APM
- Report as a Group (TIN) or Individual Clinician (TIN/NPI)
- Pay adjustments – TIN/NPI

Payment Adjustments Based on Sample CMS Threshold

	CPS	Initial Adj	Est Add'l Incentive
MAXIMUM SCORE	100	4.0%	10.0%
	95	3.5%	7.9%
	90	3.0%	6.3%
	85	2.5%	4.8%
	80	2.0%	3.2%
	75	1.5%	1.6%
(Max-Threshold)*25%	70	1.0%	0.5%
PROVIDER SCORE	67.98	0.8%	
	65	0.5%	
EXAMPLE: CMS THRESHOLD	60	0%	
	55	-0.3%	
	50	-0.7%	
	45	-1.0%	
	40	-1.3%	
	35	-1.7%	
	30	-2.0%	
	25	-2.3%	
	20	-2.7%	
THRESHOLD x 25%	15	-4.0%	

Composite Performance Score 0 to 100

Category	First Year (2017 data)	Second Year (2018 data)	Third Year+ (2019 data)
Quality	50%	45%	30%
Resource Use	10%	15%	30%
Performance Improvement	15%	15%	15%
Advancing Care Info (MU)	25%	25%	25%

Quality Category

- 300+ measures
  - Subsets: Outcome Measures, High Priority Measures, Cross-cutting Measures
  - 27 specialty sets defined
- Report 6 measures
  - 1 of 6: Cross-Cutting Measure
  - 1 of 6: Outcome Measure*
  - Report on 90% of eligible patients (all payers)

* If no applicable Outcome Measure, 1 of 6 must be a High Priority Measure

Quality Category

- Report via Registry, QRDC, EHR
- Report via Claims: Individual Clinicians only; 80% of eligible Medicare patients
- No Measure Groups
- CMS adds 2-3 'Population Based' Measures:
  - Acute Care Composite Measure
  - Chronic Care Composite Measure
  - All Cause Hospital Readmission Rate (NA for practices with < 10 eligible clinicians)

Quality Scoring

- Each measure is scored on scale of 0-10 based on performance vs national distribution
- 0 assigned to any measure not reported at 90% level (80% for claims)
- Not scored if < 20 in denominator
- Measure scores are summed and divided by maximum possible points (10 * # measures)

Score for Each Measure

For each measure, performance rates for all providers are arrayed high to low and divided so that there are 10 groups with an equal number of providers.

SAMPLE DECILE ARRAY Total #=100	Decile	Perf Score Range
10 providers with highest scores	10	62%-100%
Next 10 highest scores	9	58%-62%
Next 10 highest scores	8	**42%-58%**
Next 10 highest scores	7	40%-42%
Next 10 highest scores	6	37%-40%
Next 10 highest scores	5	30%-37%
Next 10 highest scores	4	23%-30%
Next 10 highest scores	3	20%-23%
Next 10 highest scores	2	8%-20%
10 providers with lowest scores	1	.1%-8%

A provider with a performance rate of 50% would fall into Decile 8. 50% is exactly half-way between 42% and 58% so this provider is assigned a score of 8.5 for this measure.

Calculating a Single Quality Score

The maximum score for each measure is 10.

The provider's score on each measure is summed and divided by the maximum possible score for all measures.

If a measure is not reported, it is scored as 0.

	Decile*	Score	Max
Measure 1	5	5.8	10
Measure 2	7	7.2	10
Measure 3	3	3.4	10
Measure 4	10	10.0	10
Measure 5	8	8.2	10
Measure 6	Not Rept'd	0.0	10
Measure 7 (CMS)	5	5.9	10
Measure 8 (CMS)	4	4.2	10
Measure 9 (CMS)	6	6.3	10
TOTAL		51.0	90

Quality Score: 51.0 / 90 = 56.7

Resource Use Score from Claims Data

Measures and Attribution similar to current VBM. 40 New Episode Measures

Scoring similar to Quality Measures

If a measure cannot be scored because of low volume, that measure is removed from both columns

	Decile*	Score	Max
Per Capita Cost	5	5.2	10
MSPB - Hospital Episode	7	7.8	10
Episode 1 Cost	2	2.5	10
Episode 2 Cost	NA (< 20)	NA	0
TOTAL		15.5	30

Resource Use Score: 15.5 / 30 = 51.7

Advancing Care Information Category

BASE SCORE

9 measures
Yes/No = Yes
Numerator > 0

All or Nothing
0 or 50 points

Maximum Points:
2017: 50+50=100
2018: 50+80=130 (capped at 100)

PERFORMANCE SCORE

2017: 5 measures from Modified Stage 2

2018: Add 3 measures from Stage 3

Each measure worth 10 points:

Calculating an ACI Score (2017)

Measure	Num	Denom	Rate	Base Score	Perf Score
Security Risk Assessment				OK	
Eprescribing	1400	1500	93%	OK	
Pt Electronic Access to Data	850	1000	85%	OK	8.5
Pt View/Download/Transmit Data	1	1000	0%	OK	0.0
Pt Specific Education	500	1000	50%	OK	5.0
Secure Messaging (sent)	1	1000	0%	OK	0.0
Health Info Exchange (Elec SOC)	25	100	25%	OK	2.5
Medication Reconciliation	200	300	67%	OK	
Immunization Registry	Excl			OK	
Points (No Bonus Points)				**50**	**16.0**

Total Adv Care Info Score: 66.0

Providers Not Previously in MU

- Hospital-Based
- Non Patient Facing (Anes, Pathology, Rad)
- PA, NP, CNS, CRNA
- Hardship Exemptions

Advancing Care Information Score = 0

25% weight for ACI category is reassigned to Quality category*

*if quality category has at least 3 scored measures

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CPIA Category

- Clinical Performance Improvement Activity
- 90 activities to choose from
  - Medium weight: 10 points
  - High weight: 20 points
  - Maximum points for category: 60
- Must perform activity consistently during any 90 day period of reporting year
- Report via attestation

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CPIA – Special Circumstances

- Full Credit:
  - Patient Centered Medical Home Recognition (NCQA, AAAHC, JCAH or URAC, also PCSP)
  - Practice w/ < 15 providers – any 2 activities
  - Practice in rural area or HPSA – any 2 activities
  - Non patient-facing provider – any 2 activities
- 50% Credit if participating in APM

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CPIA – Examples:

- Medium:
  - Each patient linked to clinician or care team
  - Pt satisfaction survey & improvement plan
  - Specialists provides reports to referring MD
  - Participation in QCDR
- High:
  - See Medicaid patients in a timely manner
  - Consult RX Monitoring Program before prescribing controlled substances

Composite Performance Score

	Score	Max Possible	% of Max	Weight	Final Score
Quality	51.0	90	56.7	50%	28.4
Adv Care Info (MU)	66.0	100	66.0	25%	16.5
CPIA	60.0	60	100.0	15%	15.0
Resource Use	15.5	30	51.7	10%	5.2
TOTAL				**100%**	**65.1**

CMS sets threshold annually

Earn higher or lower payment based on CPS Score

Adjustments at TIN/NPI level – 2 years after reporting year

	CPS	Initial Adj	Est Add'l Incentive
MAXIMUM SCORE	100	4.0%	10.0%
	95	3.5%	7.9%
	90	3.0%	6.3%
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	25	-2.3%	
	20	-2.7%	
THRESHOLD x 25%	15	-4.0%	

Exceptional Performance Bonus

- Bonus pool of $500M per year divided among TIN/NPI with highest CPS
- First Year Proposal: Top 75% > Threshold
- Added to payment rate (0.1 to 10%)
- Unlikely, but possible to earn +22% in 2019

Special Rules for Some

- Small practices (< 15) - CPIA
- Non-patient facing clinicians (< 25 claims for defined CPTs filed to Medicare) - CPIA, reweighting categories
- Providers listed in any APM
  - Varies by type of APM
  - No Resource Use Score (reweight categories)
  - APM participants receive same score based on average of participants

Timeline

- Proposed Rule
  - 60 day comment period: June 27th
  - Expect Final Rule in November
  - Elections ????
- Reporting year starts January 2017
  - Start quality measure data capture early
- Data Submission: January-March 2018
- Final Feedback Reports: Fall, 2018
- Payment Adjustments start January 2019

What You Should Do Now

- Learn all you can; submit comments
- Participate in PQRS, MU for 2016
- Review QRUR report for historical view
- Make a preliminary plan:
  - Confirm participation in APM & Advanced APM
  - Compare proposed quality measures to current PQRS work; prepare for changes
  - Estimate scores for each category and potential impact on Medicare revenue

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Resources

- CMS Website: http://go.cms.gov/QualityPaymentProgram
- Proposed Rule (see Table A-H at end): https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf
- Your Specialty Association, MGMA, AMA, State Medical Society, Regional Extension Center
- MSOC Health: www.msochealth.com

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QUESTIONS?

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