MACRA Proposed Rule – MIPS and APMs CHA Member Forum

Monday, June 6th from 12:30 – 1:30 pm PST

Dial-in: 1-844-378-6479
Ask to be joined to the California Hospital Association Call
Adobe Connect:
http://connectpro16666225.adobeconnect.com/ffy17macra/

CALIFORNIA HOSPITAL ASSOCIATION

CHA Presenters

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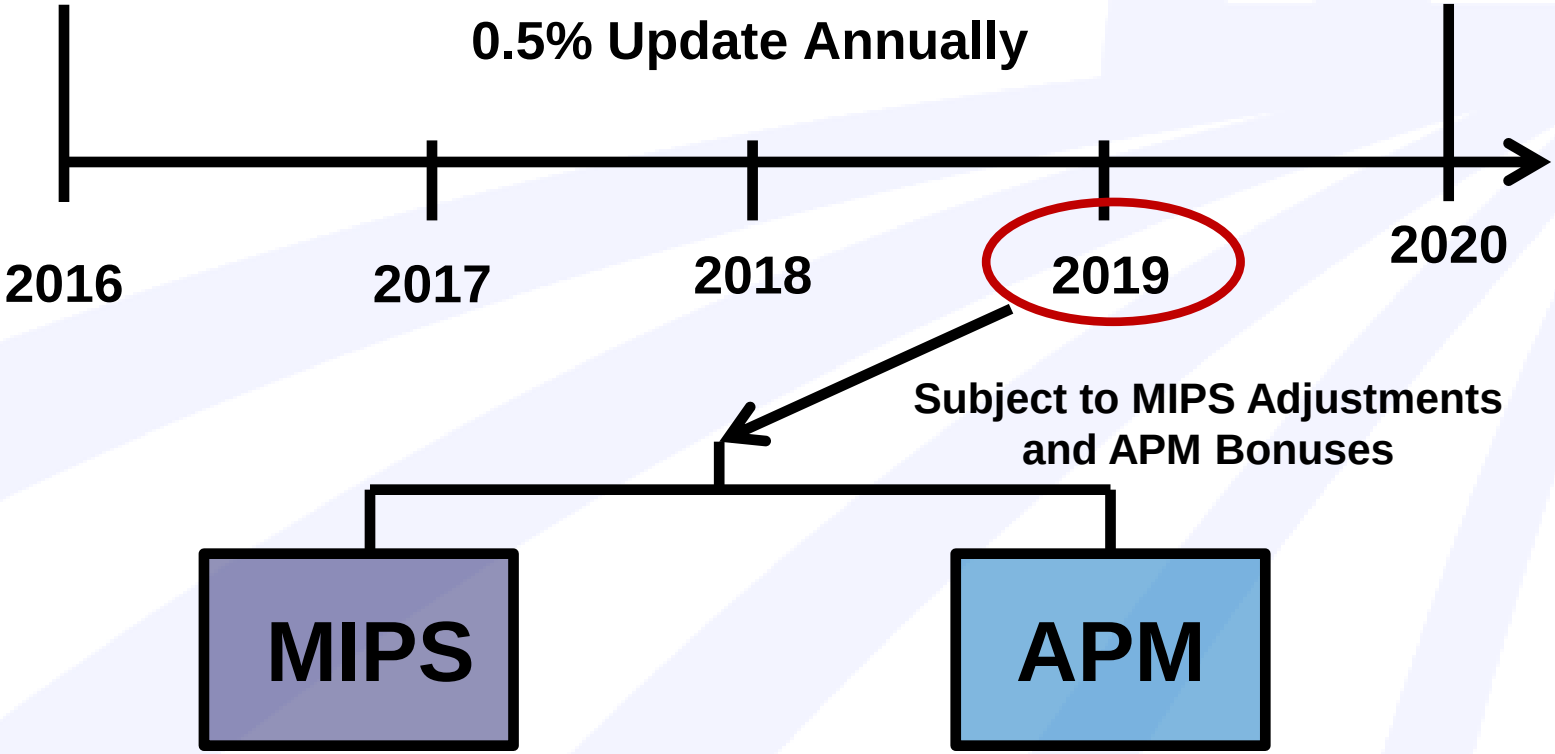
Agenda

- Overview of Proposed Rule
  - Merit-Based Payment System
  - Alternative Payment Models
- Discussion: CHA Comments

What is MACRA?

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed on April 16, 2015
  - Repeals the Sustainable Growth Rate (SGR) formula
  - Shifts physician payments toward value over volume
  - Streamlines multiple quality programs under the new Merit-Based Incentive Payment System (MIPS)
    - PQRS, Value-Based Payment Modifier, Medicare EHR Incentive Programs
  - Provides bonus payments for participation in eligible Alternative Payment Models (APMs)

Annual Payment Updates



Graphic Source: American Hospital Association

The Merit-Based Incentive Payment System (MIPS)

MIPS – Who is eligible?

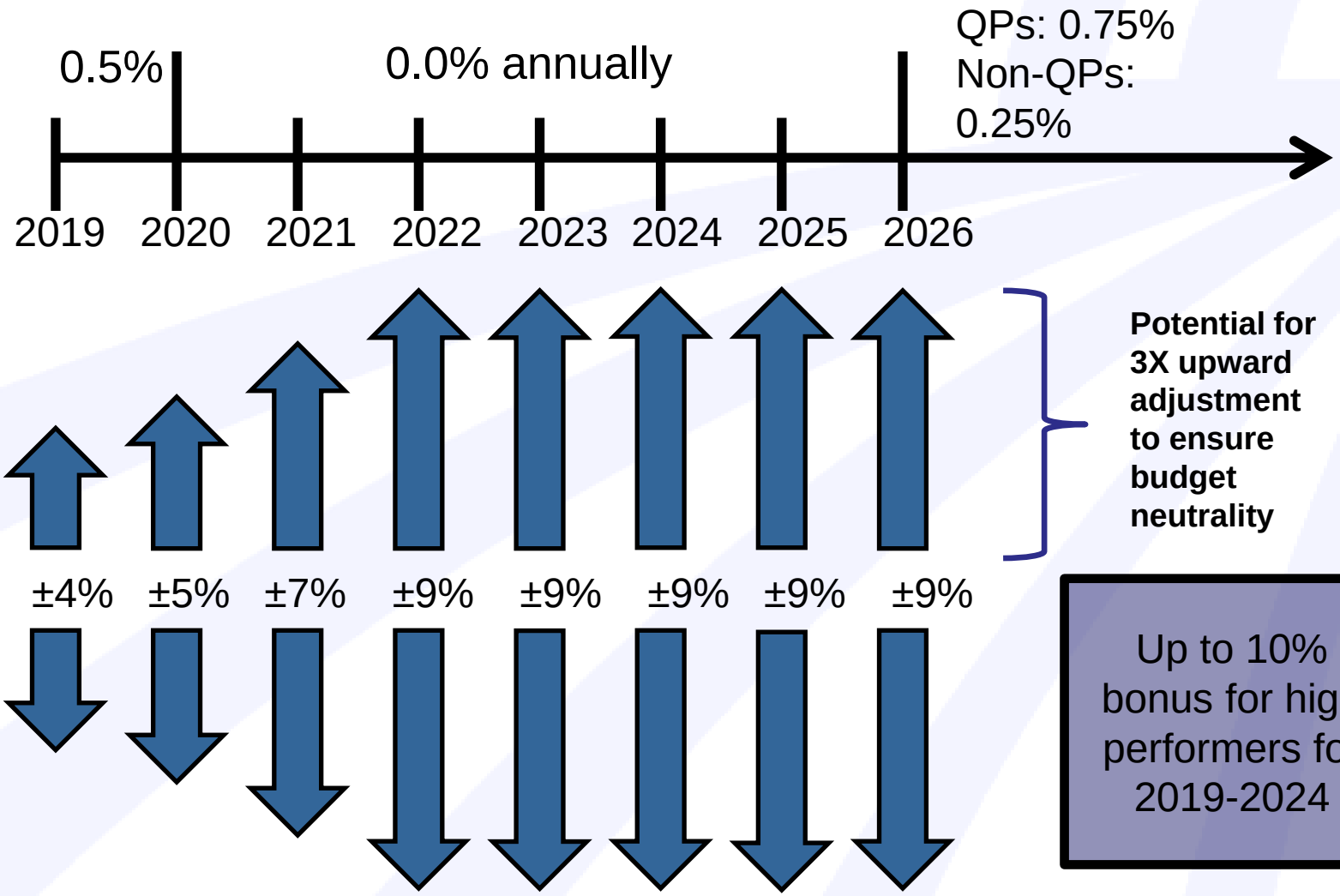
- Years 1 and 2:
  - Physicians (MD/DO and DMD/DDS), PAs, NPs, Clinical nurse specialists, Certified registered nurse anesthetists
- Years 3+
  - **Secretary may broaden Eligible Clinicians group to include others such as:** Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals

MIPS – Who is excluded?

- There are 3 groups of clinicians who will not be subject to MIPS:
  - FIRST year of Medicare Part B participation
  - Below low volume threshold:
    - Medicare billing charges less than or equal to $10,000 **and** provides care for 100 or fewer Medicare patients in one year
  - Qualified participants (QPs) and Partial QPs in Advanced APMs

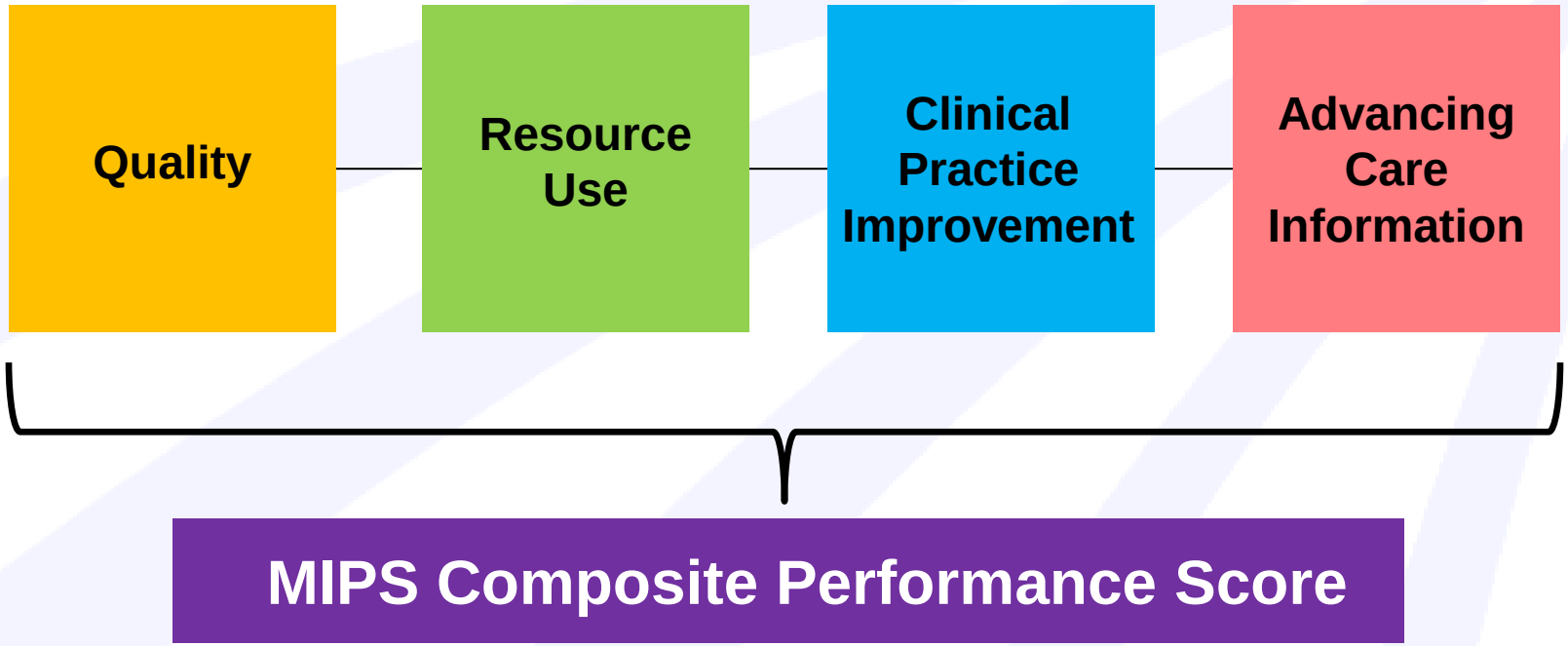
❖ Note: MIPS does not apply to hospitals or facility payments

Payment Adjustments under MIPS



MIPS Performance Evaluation

- Professionals scored on a composite score based on four categories:



MIPS Composite Score Category Weights

Category	CY 2019	CY 2020	CY 2021 and beyond
Quality	50%	45 %	30%
Resource Use	10%	15 %	30%
Clinical Practice Improvement Activities	15 %	15 %	15 %
Advancing Care Information	25 %	25 %	25 %

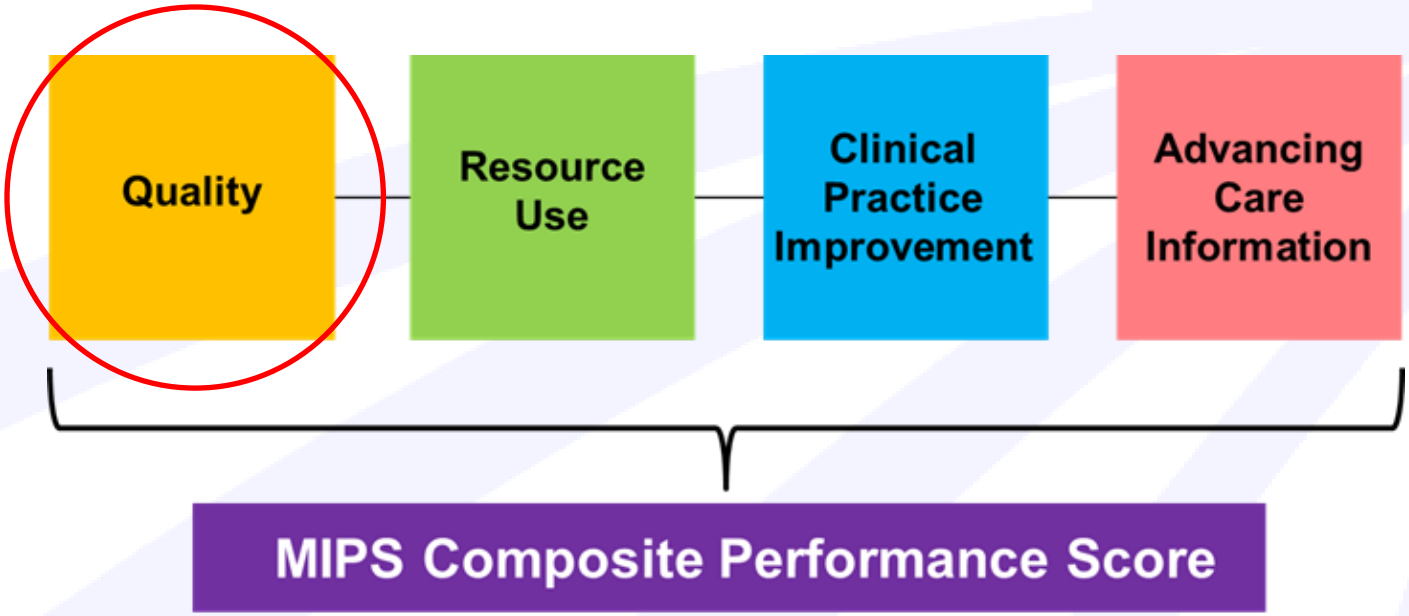
Proposed MIPS Timeline

- First Performance Period
  - January 1- December 31, 2017
- First Data Submission Period
  - January 2 – March 31, 2018
- MIPS Adjustment applies to Medicare Part B payments beginning January 1, 2019

MIPS Data Submission Options

	Individual Reporting	Group Reporting
Quality	Claims Qualified Clinical Data Registry (QCDR) Qualified registry EHR Administrative claims (no submission required)	Qualified Clinical Data Registry (QCDR) Qualified registry EHR CMS Web Interface (groups ≥ 25) CMS-approved survey vendor for CAHPS for MIPS (must be reported in conjunction with another data submission mechanism) Administrative claims (no submission required)
Resource Use	Administrative claims (no submission required)	Administrative claims (no submission required)
Clinical Practice Improvement	Attestation Qualified Clinical Data Registry (QCDR) Qualified registry EHR Administrative claims (no submission required)	Attestation Qualified Clinical Data Registry (QCDR) Qualified registry EHR CMS Web Interface (groups ≥ 25) Administrative claims (no submission required)
Advancing Care Information	Attestation Qualified Clinical Data Registry (QCDR) Qualified registry EHR	Attestation Qualified Clinical Data Registry (QCDR) Qualified registry EHR CMS Web Interface (groups ≥ 25)

MIPS Quality Performance Category



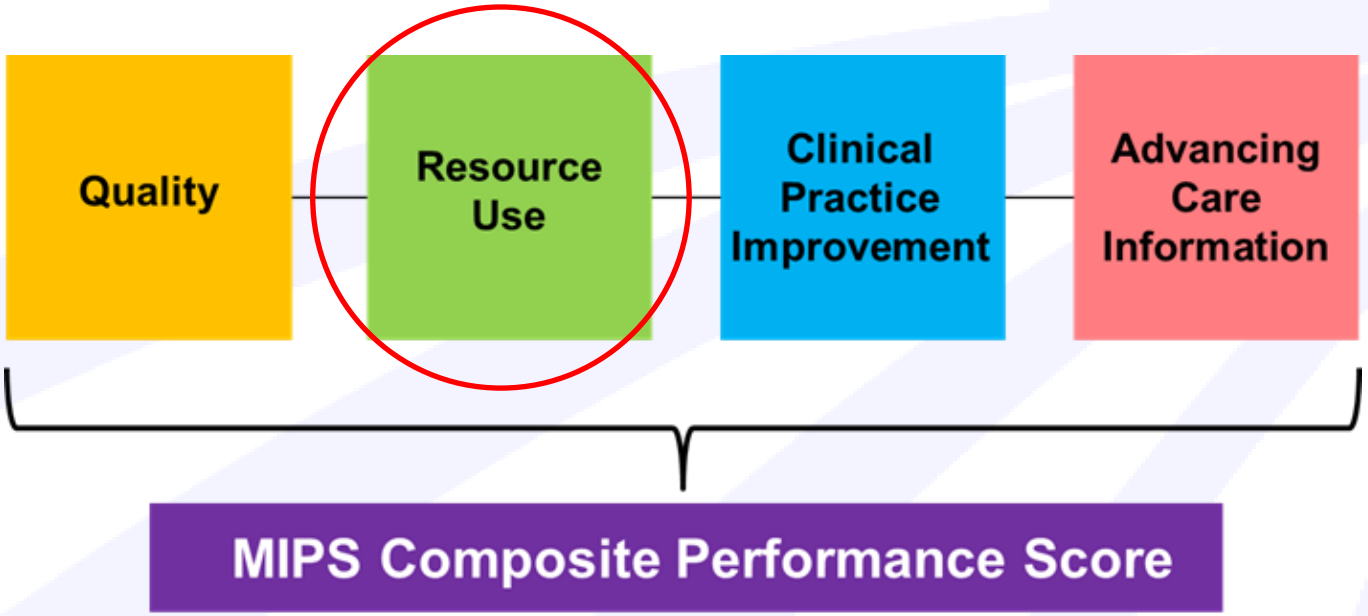
MIPS Quality Performance Category

- Eligible clinicians select 6 measures to report
  - 1 cross-cutting measure and 1 outcome measure, or another high priority measure if outcome is unavailable
  - Select from individual measures or a specialty measure set
- Up to 3 global and population measures automatically calculated for groups of 10 or more eligible clinicians
  - Acute Conditions Composite, Chronic Conditions Composite, All-Cause Hospital Readmissions Measure
- Measures are scored on a 1-10 point range against a historical benchmark and then averaged.

MIPS Quality Performance Category – Facility-Based Clinicians Reporting

- CMS seeks comments on the following issues related to facility-based MIPS eligible clinicians:
  - Under what conditions it would be appropriate to attribute hospital quality measures to clinicians
  - Criteria for attributing a facility's performance to a MIPS eligible clinician
  - Specific measures for which CMS can use the facility's quality and resource use measures as a proxy for the MIPS eligible clinician's performance
  - Whether attribution of particular eligible clinicians should be done on an "automatic" basis or through the use of a registration process

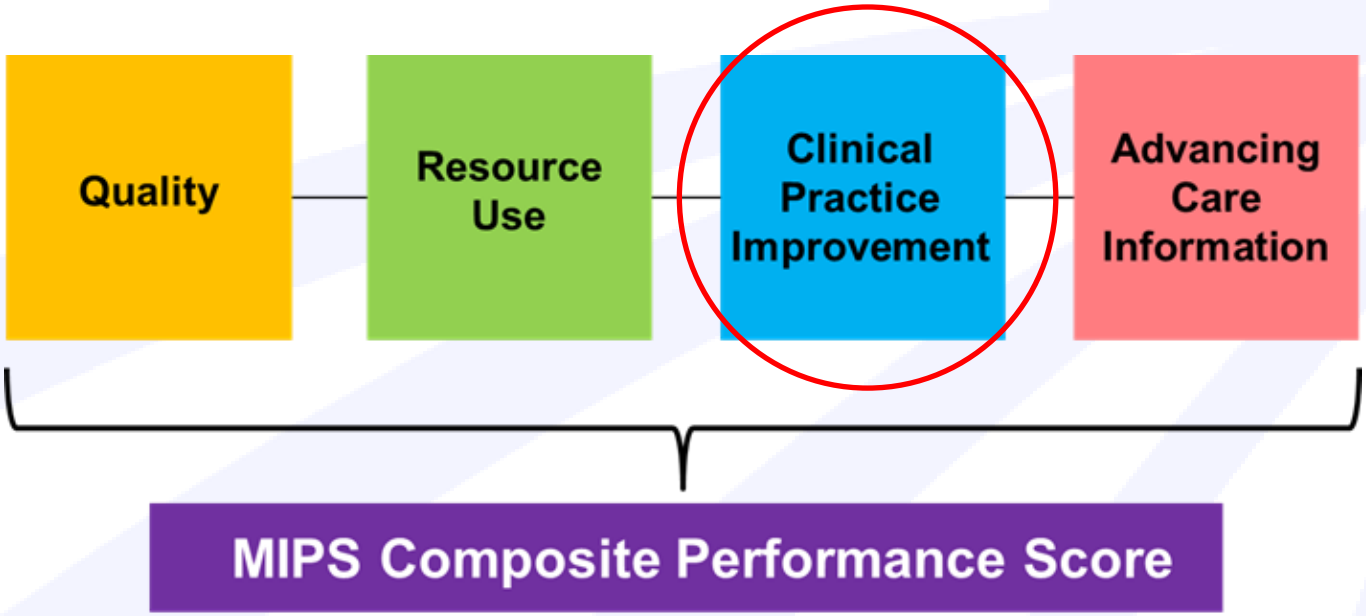
MIPS Resource Use Performance Category



Resource Use Performance Category

- CMS proposes to keep two measures from the value-based modifier:
  - Total costs per capita
  - Medicare spending per beneficiary
- CMS will assess eligible clinicians as many on episode-based measures as can be attributed to the clinician from a list of 41
- CMS calculates based on administrative claims so there are no reporting requirements for clinicians
- Measures are scored on a 1-10 point range against a baseline benchmark and then averaged

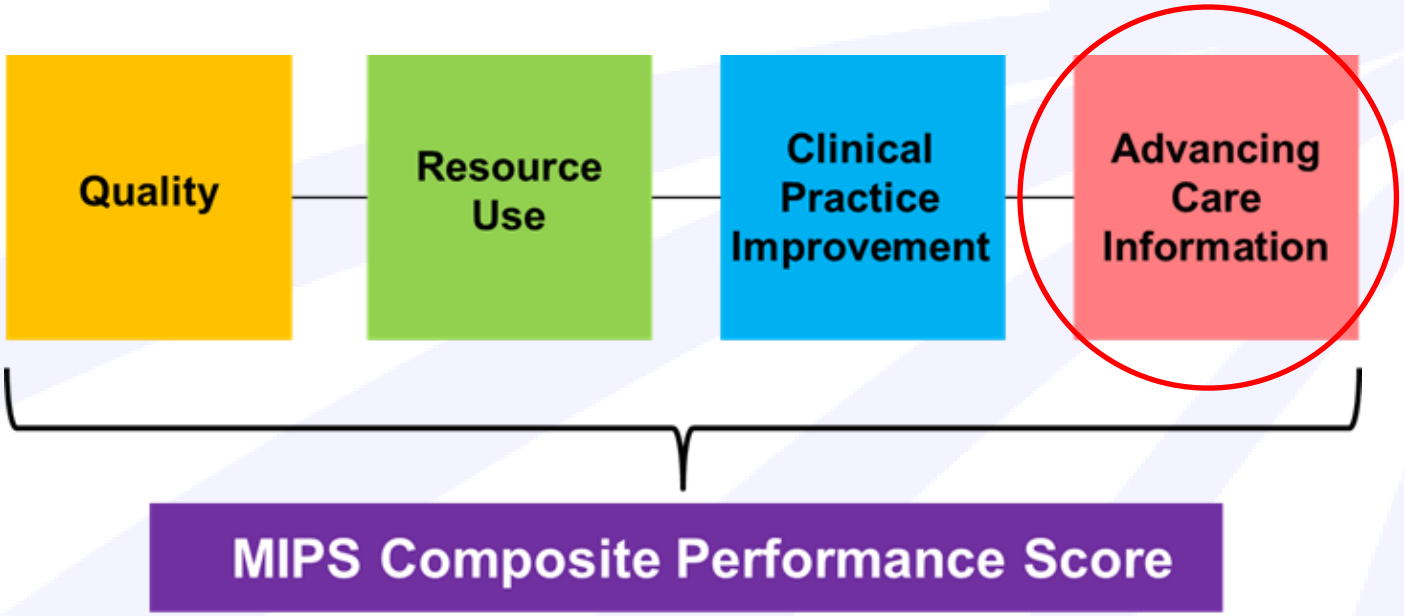
MIPS Clinical Practice Improvement Performance Category



Clinical Practice Improvement Performance Category

- CMS proposes the eligible clinicians choose to report at least one activity from a list of more than 90 options
- Eligible clinicians can reach a maximum score of 60, with activities weighted from 10 to 20 points
- Certain exceptions for:
  - Participants in patient-centered medical homes
  - Participants in APMs
  - MIPS eligible clinicians or groups in small practices, in rural areas, in geographic HPSAs, and non-patient facing clinicians.

MIPS Advancing Care Information Performance Category

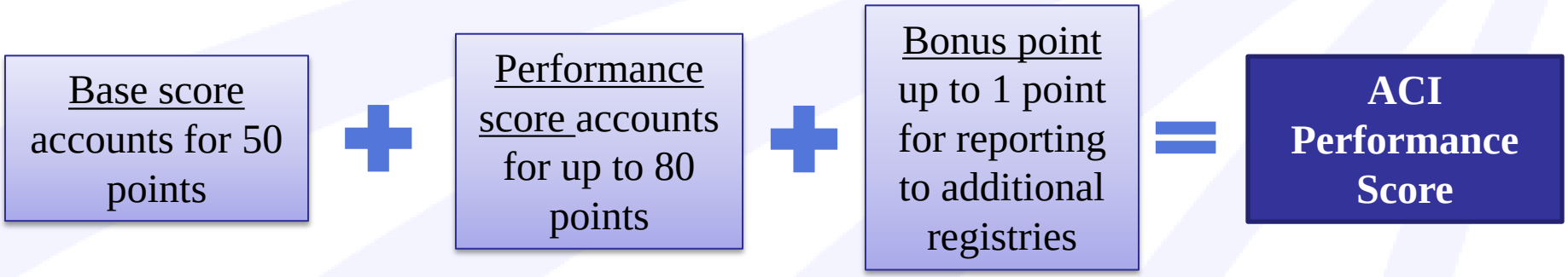


Advancing Care Information Performance Category

- The Advancing Care Information performance category replaces the Medicare EHR Incentive program for physicians
- All MIPS eligible clinicians are eligible to participate, exceptions for:
  - NPs, PAs, CNSs and CRNAs
  - Hospital-based MIPS eligible clinicians
  - Eligible clinicians facing significant hardship

Advancing Care Information Performance Category

The overall Advancing Care Information score would be made up of a base score and a performance score for a maximum score of 100 points:



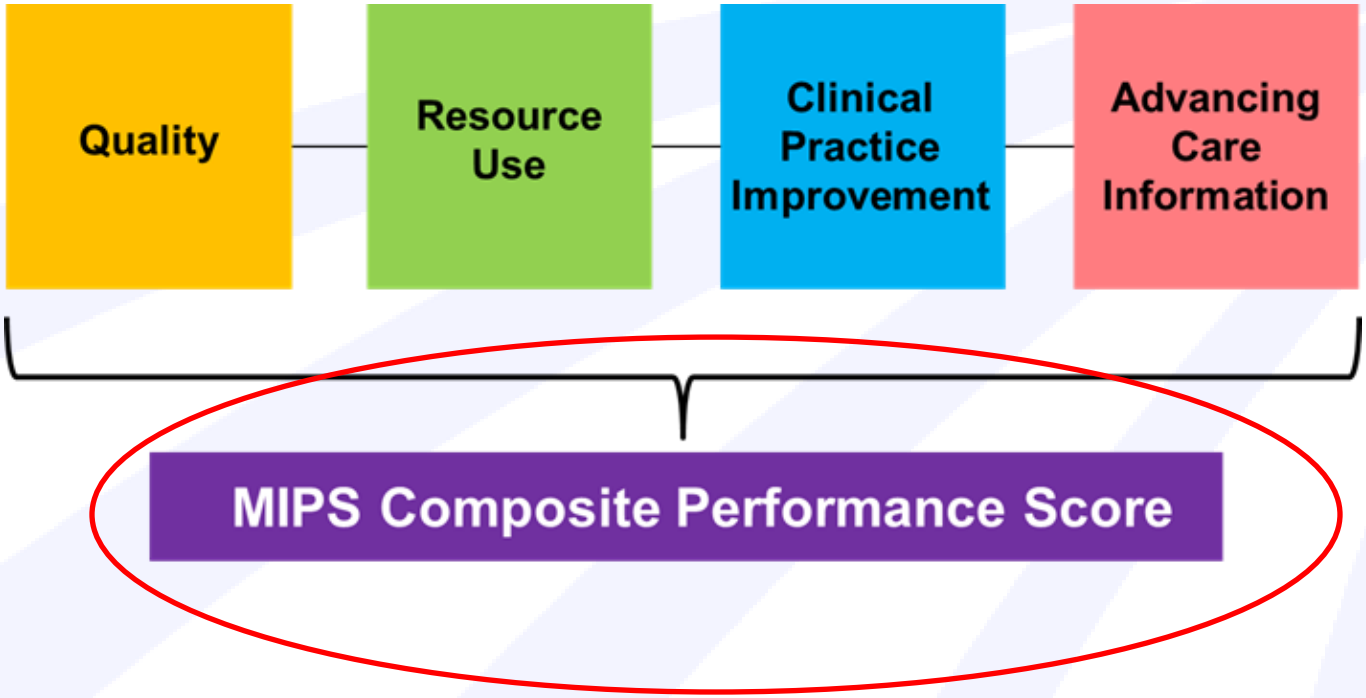
Earn 100 or more points to receive full 25 points in the Advancing Care Information Category of MIPS Composite Score

Advancing Care Information Performance Category

- CMS proposes six objectives and their measures that would require reporting for the base score:
  - Eligible Clinicians must respond Yes or provide a numerator and denominator for each measure to receive the base score
- CMS proposes that a MIPS eligible clinician would earn additional points above the base score for performance on eight associated measures that would each be assigned a total of 10 possible points.
  - No associated achievement thresholds are set

ACI Objective	ACI Measure	ACI Base Score	ACI Performance Score
Protect Patient Health Information	Conduct or review security risk analysis and implement security updates as necessary	Yes Required	N/A
Electronic Prescribing	At least 1 permissible prescription transmitted electronically	Numerator/Denominator	N/A
Patient Electronic Access	At least 1 unique patient/family rep provided timely e-access to their health information	Numerator/Denominator	% of patients
	At least 1 unique patient provided e-access to patient-specific educational materials	Numerator/Denominator	% of patients
Coordination of Care through Patient Engagement	At least 1 unique patient / family rep actively engages with EHR via VDT or API	Numerator/Denominator	% of patients
	Secure message sent (or responded to) for at least 1 unique patient / family rep	Numerator/Denominator	% of patients
	PGHD or data from non-clinical setting incorporated into CEHRT for at least 1 unique patient	Numerator/Denominator	% of patients
Health Information Exchange	At least 1 transition of care / referral summary of care (SOC) is created & e-exchanged	Numerator/Denominator	% of patients
	At least 1 transition of care / referral summary of care (SOC) is e-received and incorporated	Numerator/Denominator	% of patients
	At least 1 transition of care / referral clinical information reconciliation is performed for (1) Meds (2) Med allergies AND (3) Current problem list	Numerator/Denominator	% of patients
Public Health and Clinical Data Registry Reporting	Immunization registry reporting (plus 4 optional registries, bonus point available for reporting additional registry)	Yes Required	N/A

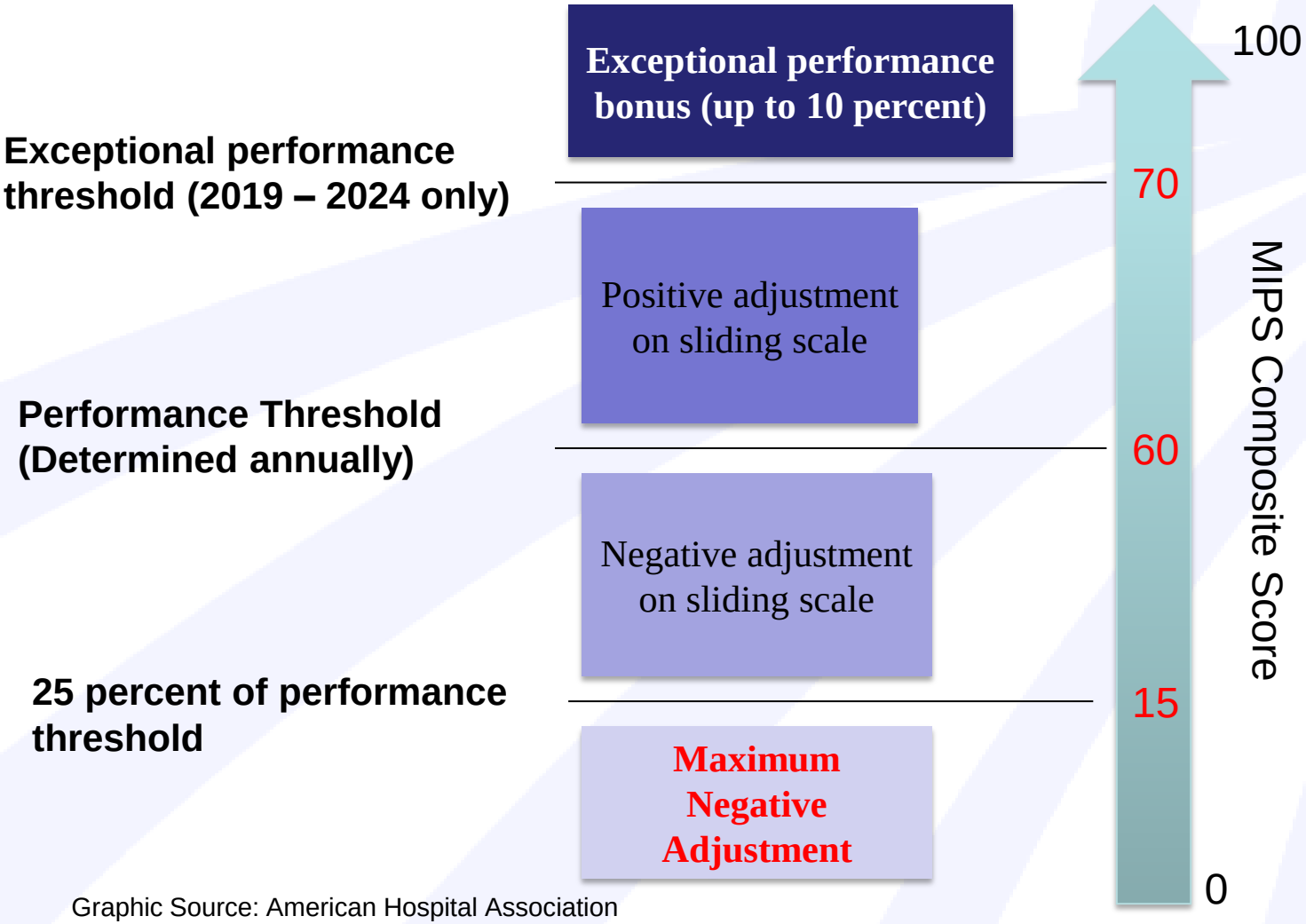
MIPS Advancing Care Information Performance Category



Calculating the Composite Performance Score (CPS) for MIPS

	Weight	• Scoring
Quality	50%	• Each measure 1-10 points compared to historical benchmark (if available) • 0 points for a measure that is not reported • Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR reporting • Measures are averaged to get a score for the category
Resource Use	10%	• Each measure 1-10 points compared to baseline benchmark • Measures are averaged to get a score for the category
Clinical Practice Improvement Activities	15%	• Each activity worth 10 or 20 points • Sum of activity points compared to a target of 60 possible points
Advancing Care Information	25%	• Base score of 50 points is achieved by reporting at least one use case for each available measure • Up to 10 additional points available per performance measure • 1 bonus point for reporting to additional registries above base requirement • Total cap of 100 percentage points available

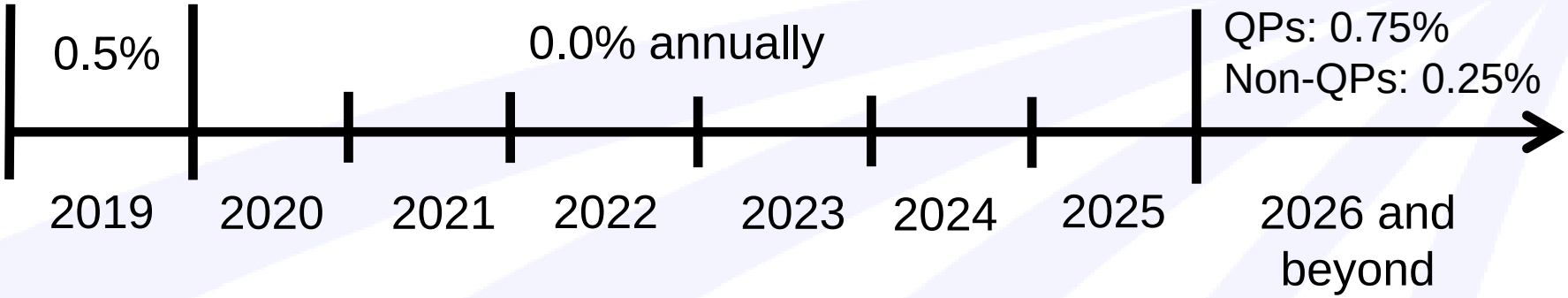
Translating the MIPS Composite into Incentives and Penalties



Graphic Source: American Hospital Association

Alternative Payment Models (APMs)

Payment Under APMs



APM: Bonus of 5% of PFS payments annually for Qualifying APM Professionals (QPs) 2019-2024

Alternative Payment Models (APMs)

- MACRA defines an APM as:
  - A model tested by the CMMI, other than a health care innovation award
  - An ACO under the Medicare Shared Savings Program
  - The Health Care Quality Demonstration Program
  - A demonstration required by federal law

Advanced APM Criteria

- As defined by MACRA, Advanced APMs must meet the following criteria:
  - The APM requires participants to use certified **EHR technology.**
  - The APM **bases payment on quality** measures comparable to those in the MIPS quality performance category.
  - The APM either: (1) requires APM Entities to bear more than nominal **financial risk** for monetary losses; **OR (2)** is a **Medical Home Model expanded** under CMMI authority.

Current Advanced APMs

- Based on the proposed criteria, CMS has identified the following APMs as Advanced APMs:
  - Shared Savings Program (Tracks 2 and 3)
  - Next Generation ACO Model
  - Comprehensive ESRD Care(CEC) (large dialysis organization arrangement)
  - Comprehensive Primary Care Plus (CPC+)
  - Oncology Care Model (OCM) (two-sided risk track available in 2018)

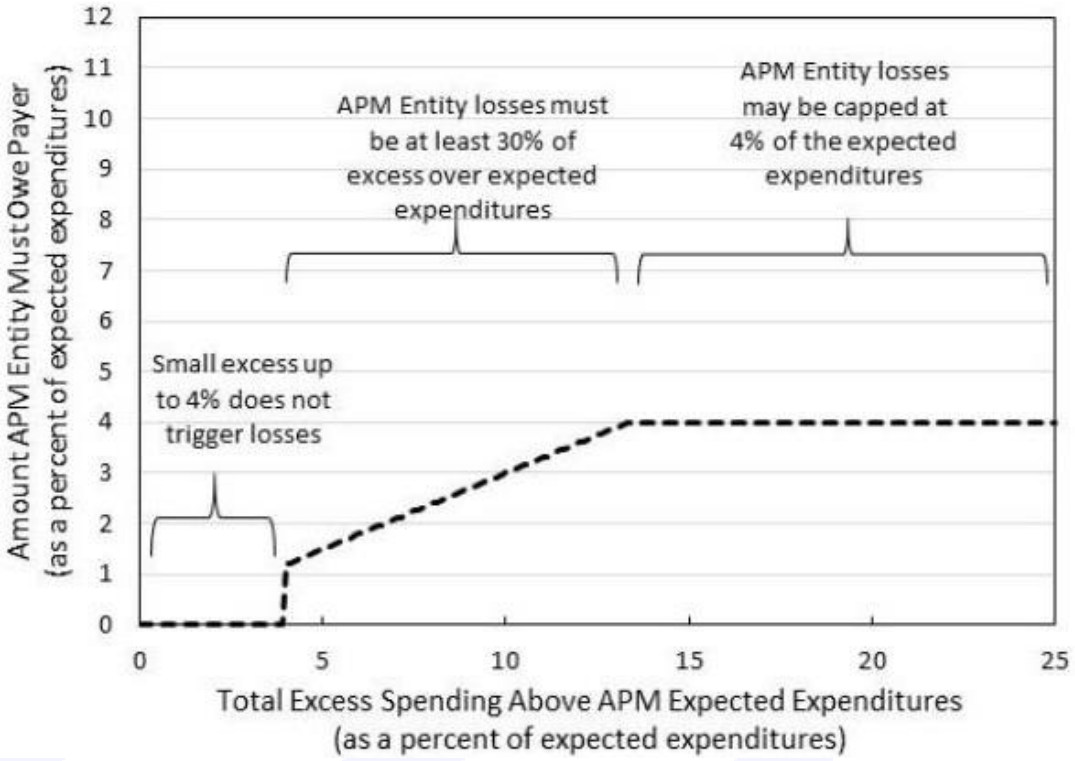
APM Entity

- An APM entity holds primary responsibility for health care cost and quality provided to beneficiaries as governed by its direct agreement with CMS.
- All entities participating in Advanced APMs are Advanced APM entities.

Advanced APM Financial Risk Criteria

- Nominal Amount Standard: The amount of risk under an Advanced APM must at least meet the following components:
  - Total risk of at least 4% of expected expenditures
  - Marginal risk of at least 30%
  - Minimum loss ratio (MLR) of no more than 4%.

Illustration of the amount of risk an APM Entity must bear in an Advanced APM:



How do Eligible Clinicians become QPs?

- CMS will calculate a percentage "Threshold Score" for each Advanced APM Entity using two methods (payment amount and patient count).
- Methods are based on Medicare Part B professional services and beneficiaries attributed to Advanced APM Entities.
- CMS will use the method that results in a more favorable QP determination for each Advanced APM Entity.

How do Eligible Clinicians become QPs?

Medicare Option - Payment Amount Method						
Payment Year	**2019**	**2020**	**2021**	**2022**	**2023**	**2024+**
QP Payment Amount Threshold	25%	25%	50%	50%	75%	75%
Partial QP Payment Amount Threshold	20%	20%	40%	40%	50%	50%

Medicare Option –Patient Count Method						
Payment Year	**2019**	**2020**	**2021**	**2022**	**2023**	**2024+**
QP Payment Amount Threshold	20%	20%	35%	35%	50%	50%
Partial QP Payment Amount Threshold	10%	10%	25%	25%	35%	35%

Other Payer Advanced APM Option

- Starting in 2021, some arrangements with other non-Medicare payers can count toward becoming a QP.
- IF the "Other Payer APMs" meet criteria similar to those for Advanced APMs, CMS will consider them "Other Payer Advanced APMs":
  - Certified EHR use
  - Quality Measures
  - Financial Risk

Physician-Focused Payment Models

- MACRA includes provisions to develop Physician-Focused Payment Models
- Physician-Focused Payment Model Technical Advisory Committee (PTAC)
  - Appointments to committee announced in October 2015
  - Provides comments and recommendations to CMS for the creation and implementation of new Physician-Focused Payment Models
- https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee

MACRA Requirements: Surveillance Demonstrations and Information Blocking

- MACRA establishes new attestations required for hospitals, physicians and other clinicians regarding:
  - Surveillance demonstrations, and
  - Prevention of information blocking
- EHs, CAHs and EPs: attestation would become part of the Medicare & Medicaid EHR Incentive Payment Programs.
- MACRA eligible clinicians (both in MIPS and reporting via an APM group entity) would be subject to a similar attestation.

Discussion: Considerations for Hospitals

Enter the phone queue, email Questions to mhoward@calhospital.org or type into Adobe Q&A box

Comment Themes - MIPS

- CHA appreciates that CMS has streamlined and reduced the required number of quality measures for physicians
  - Adjust for SDS where appropriate
- Consideration of a method for allowing hospital-based physicians to use their facilities' quality reporting and pay-for-performance program measure performance in the MIPS
  - Looking for member input on specific suggestions
- Considerations for alignment between hospitals' EHR Incentive Program requirements with the Advancing Care Information requirements for physicians

MIPS Quality Performance Category – Facility-Based Clinicians Reporting

- CMS seeks comments on the following issues related to facility-based MIPS eligible clinicians:
  - Under what conditions it would be appropriate to attribute hospital quality measures to clinicians
  - Criteria for attributing a facility's performance to a MIPS eligible clinician
  - Specific measures for which CMS can use the facility's quality and resource use measures as a proxy for the MIPS eligible clinician's performance
  - Whether attribution of particular eligible clinicians should be done on an "automatic" basis or through the use of a registration process

ACI Objective	ACI Measure	ACI Base Score	ACI Performance Score	Hospital Stage 3 MU Threshold
Protect Patient Health Information	Conduct or review security risk analysis and implement security updates as necessary	Yes Required	N/A	Yes Required
Electronic Prescribing	At least 1 permissible prescription transmitted electronically	Numerator/ Denominator	N/A	More than 25 percent of EH or CAH discharge medication orders for permissible prescriptions
Patient Electronic Access	At least 1 unique patient/family rep provided timely e-access to their health information	Numerator/ Denominator	% of patients	More than 80 percent of unique patients
	At least 1 unique patient provided e-access to patient-specific educational materials	Numerator/ Denominator	% of patients	More than 35 percent of unique patients
Coordination of Care through Patient Engagement	At least 1 unique patient / family rep actively engages with EHR via VDT or API	Numerator/ Denominator	% of patients	More than 10 percent of unique patients
	Secure message sent (or responded to) for at least 1 unique patient / family rep	Numerator/ Denominator	% of patients	More than 25 percent of unique patients
	PGHD or data from non-clinical setting incorporated into CEHRT for at least 1 unique patient	Numerator/ Denominator	% of patients	More than 5 percent of unique patients
Health Information Exchange	At least 1 transition of care / referral summary of care (SOC) is created & e-exchanged	Numerator/ Denominator	% of patients	More than 50 percent of transitions of care and referrals
	At least 1 transition of care / referral summary of care (SOC) is e-received and incorporated	Numerator/ Denominator	% of patients	More than 40 percent of transitions and referrals received and patient encounters in which the provider has never encountered the patient before
	At least 1 transition of care / referral clinical information reconciliation is performed for (1) Meds (2) Med allergies AND (3) Current problem list	Numerator/ Denominator	% of patients	More than 80 percent of transitions or referrals received and patient encounters in which the provider has never encountered the patient before
Public Health and Clinical Data Registry Reporting	Immunization registry reporting (plus 4 optional registries, bonus point available for reporting additional registry)	Yes Required	N/A	EH and CAHs must report on 4 registry measures

Comment Themes - APMs

- CMS should recognize risk associated with initial investment in establishing APMs
- Consider changes to fraud and abuse laws that are barriers to clinical integration and alignment
- Consideration of capturing risk-sharing agreements in Medicare Advantage

Next Steps

- Comments are due June 27
  - CHA will have draft comment letter in *CHA News* week of June 20
- Final Rule to be issued no later than Nov. 1
- CHA will carefully review CY 2017 Physician Fee Schedule proposed rule for any additional MACRA provisions (expected mid-July)

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Additional Resources

- CHA MACRA Resource Page: http://www.calhospital.org/resource/macra-resources
  - CHA Summary: http://www.calhospital.org/macra-mips-apm-proposed-summary
- CMS MACRA Webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

Questions?

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