MACRA's Quality Payment Program: 2018 Update on Medicare's New Program for Paying Physicians and Other Healthcare Professionals

John McInnes, MD, JD, Arnold & Porter

OEIS 2018 Fifth Annual National Scientific Meeting

April 21, 2018

Agenda

- Review of MACRA Fundamentals
- Overview of Select MACRA 2018 Final Rule Provisions
- Questions & Discussion

MACRA FUNDAMENTALS

MACRA Fundamentals

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established a new Medicare payment system for physicians and other health care providers beginning in 2019.
- Most significant change in Medicare's payment system for physicians in 25 years.
- Repealed the annual ~25% payment cliffs from the Sustainable Growth Rate (SGR) formula and replaced it with a new 2-track system that makes adjustments to what would otherwise be paid under Medicare's Physician Fee Schedule.
- Maintains focus on moving from "volume to value," heightening provider incentives to make treatment decisions considering quality and resource use.
- ***Current Administration – "Putting Patients First" and "Patients Over Paperwork."***

Quality Payment Program (QPP)

- Payment system established by MACRA is called the Quality Payment Program (QPP)
- Consistent with the statute, the QPP has 2 pathways:
  - Merit-Based Incentive Payment System (MIPS)
  - Advanced Alternative Payment Models (APMs)
- Both pathways adjust Medicare fee-for-service payments for Part B services to incentivize:
  - Quality Care and Better Health Outcomes
  - Efficiency (i.e., cost savings)
  - Use of electronic health records (EHR)

Quality Payment Program (QPP) – 2018 Final Rule Principles:

1) Supports care improvement by focusing on better outcomes for patients, and preserving the independent clinical practice;
2) Promotes the adoption of Advanced Payment Models (APMs) that align incentives for high-quality, low-cost care across healthcare stakeholders; and
3) Advances existing delivery system reform efforts, including ensuring a smooth transition to a healthcare system that promotes high-value, efficient care through unification of CMS legacy programs.

The QPP's Two Pathways:

Merit-Based Incentive Payment System (MIPS)

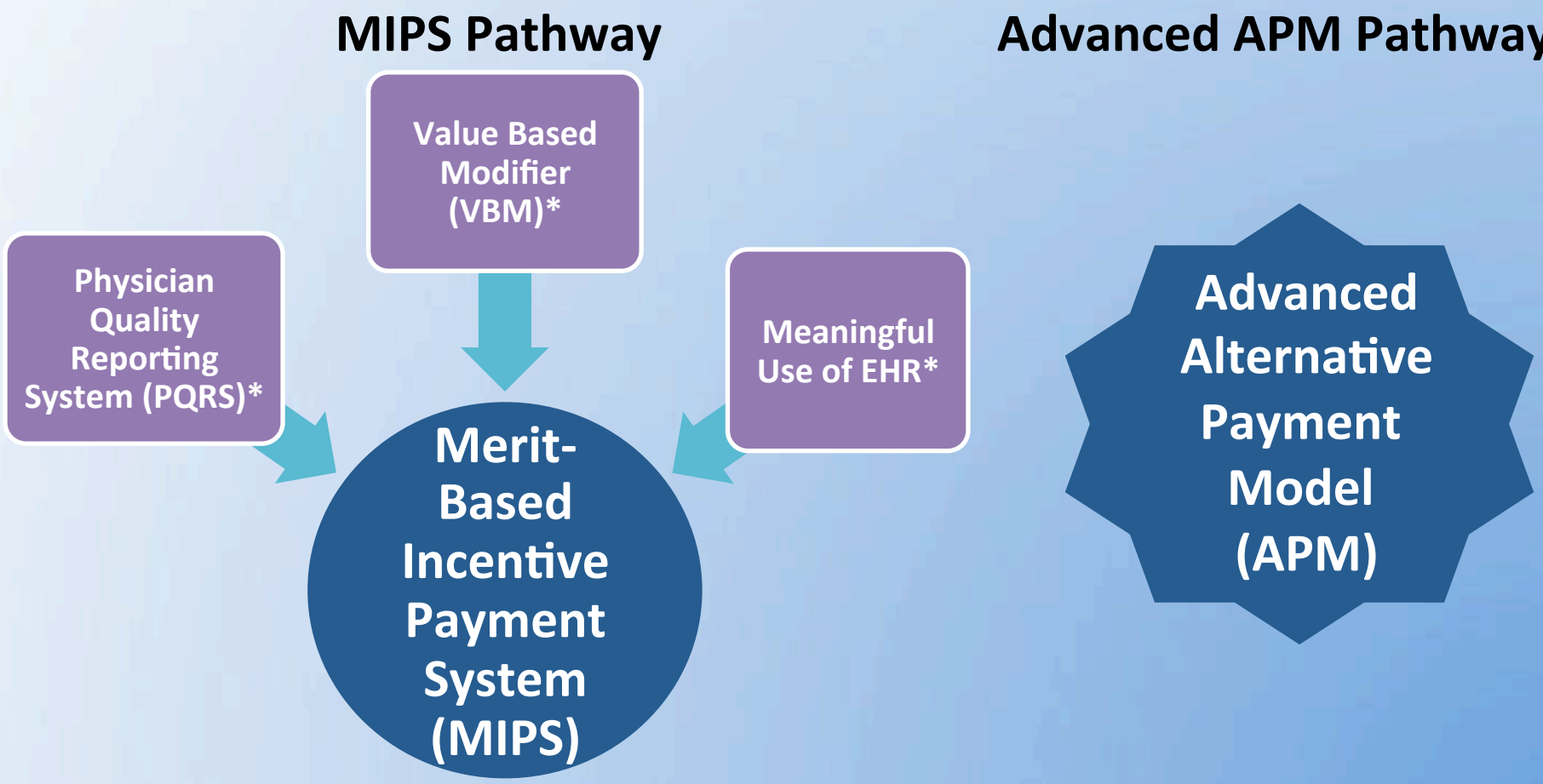
OR

Advanced Alternative Payment Models (APMs)

MIPS and Advanced APMs have some things in common:

	MIPS	APMs
Payment adjustments start January 1, 2019, based upon performance in 2017	☑	☑
Applies to Medicare fee-for-service payments (for physician services), not Medicare Advantage	☑	☑
Intended to reward higher-quality, lower-cost, higher-value care	☑	☑
Replaces the Physician Quality Reporting System (PQRS)	☑	☑
Replaces the Value Modifier	☑	☑
Replaces Meaningful Use	☑	☑

MACRA Statute: QPP Started in 2017 (Performance Year) for 2019 (Payment Year), Two New Pathways

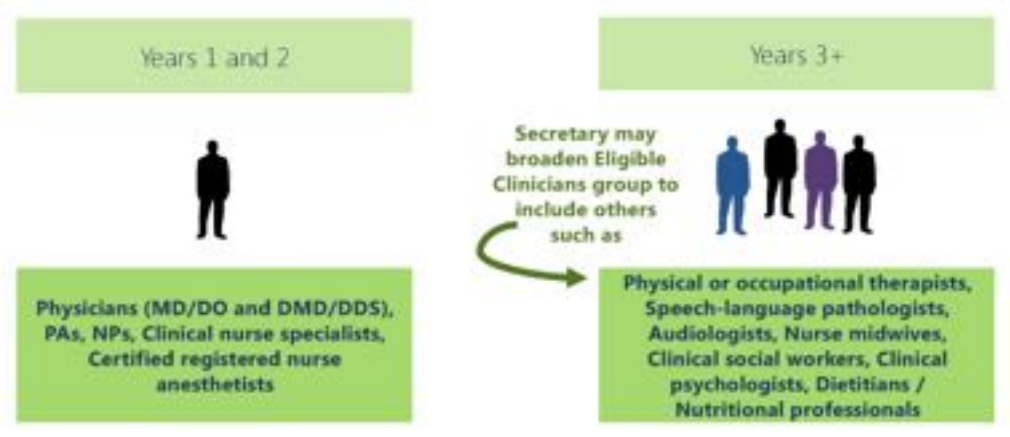


**3 Legacy Programs End after 2018 Payment Year (based on 2016 Reporting)*

2018 MACRA FINAL RULE

MIPS PATHWAY

Who participates in MIPS?



Three groups do not participate in MIPS:

1. Doctors in their first year of Medicare participation;
2. Low volume practices:
    a. ≤ $90K in Part B allowed charges, or
    b. ≤ 200 Part B beneficiaries
3. Advanced APM participants

MIPS Has Four Components with Different Weights:

MIPS Categories

Quality

Resource use (cost)

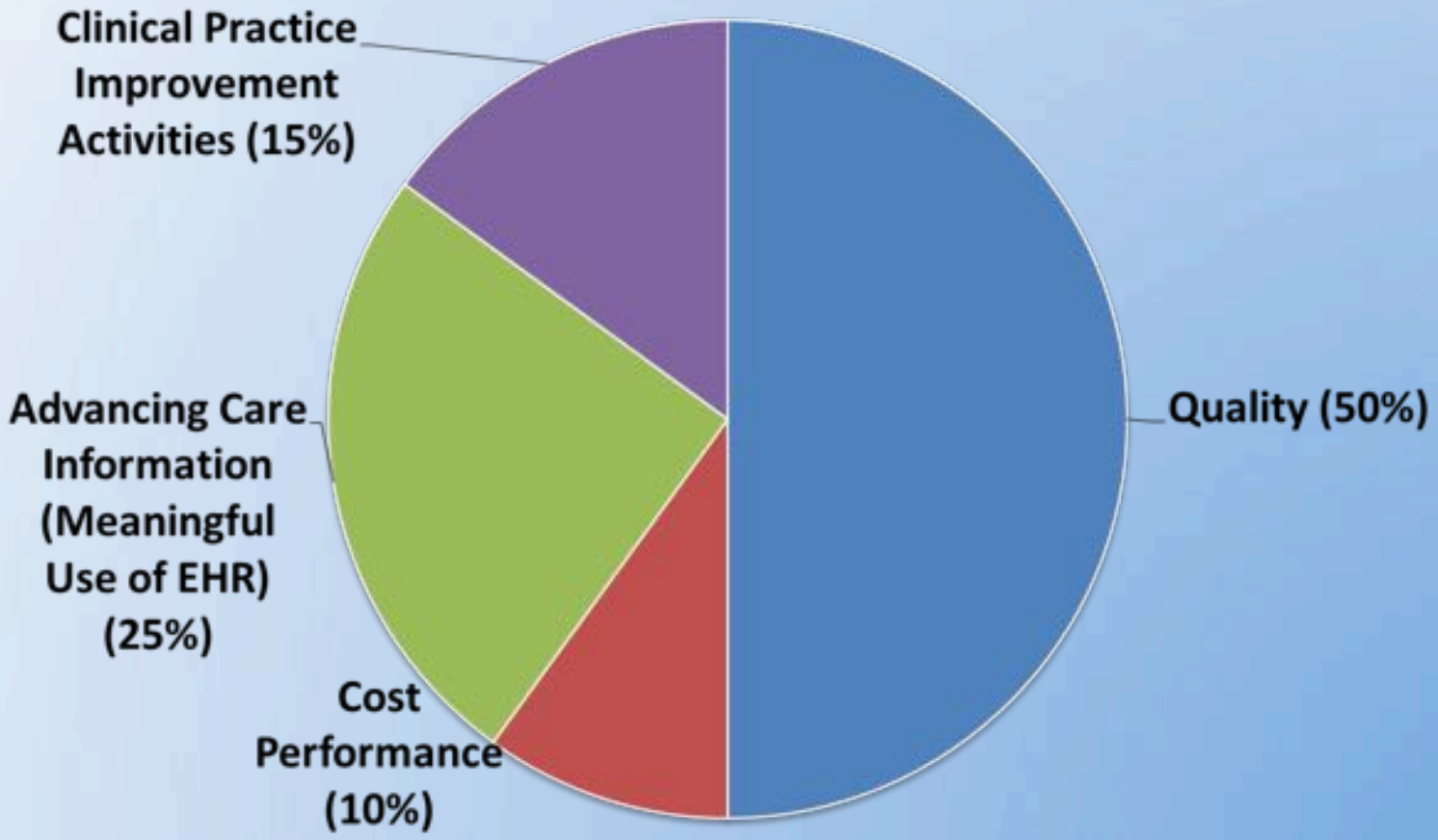
Clinical practice improvement activities

"Advancing Care information" (ak a meaningful use of EHR)

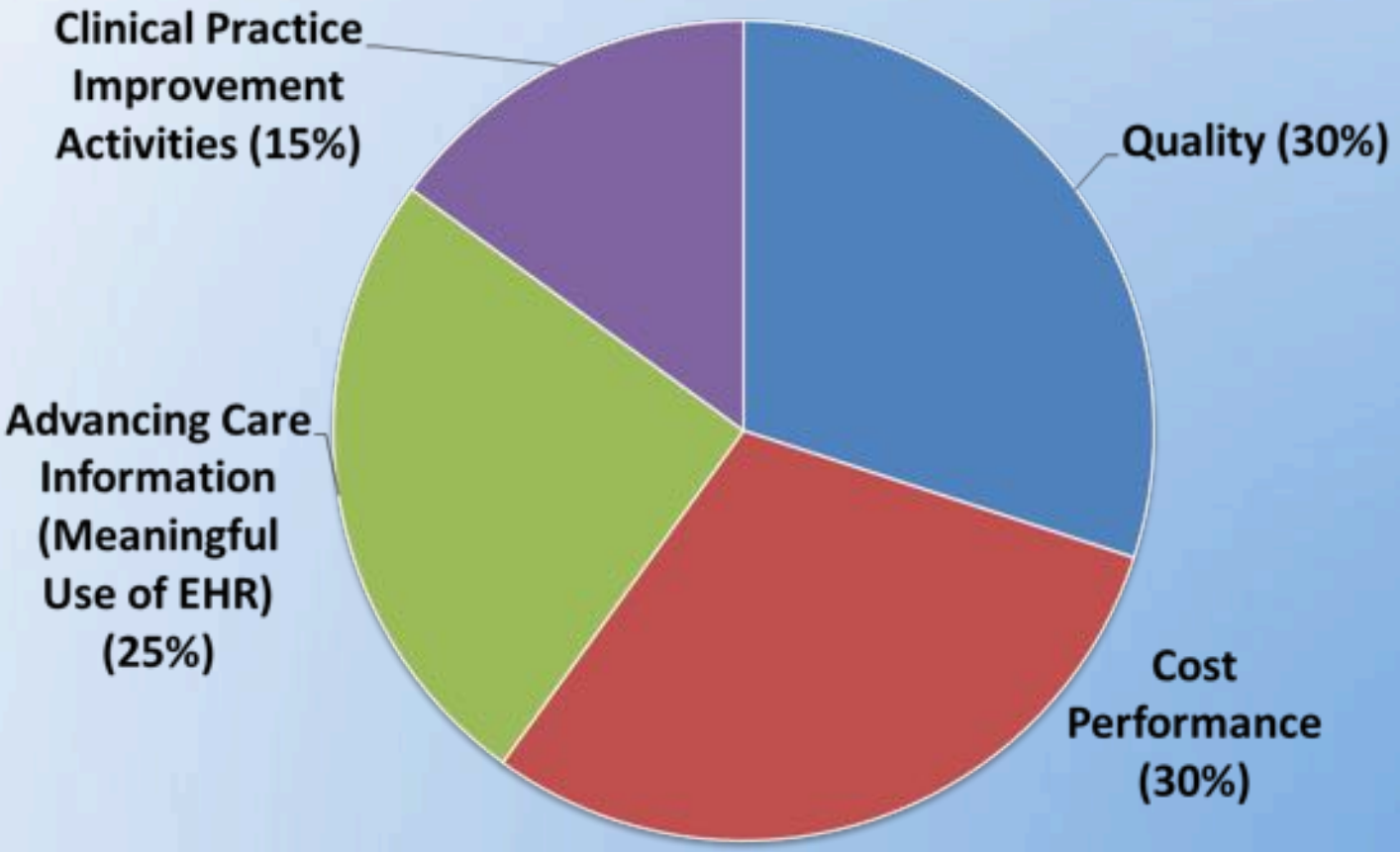
MIPS Composite Performance Score (CPS) (0-100)

The CPS compared to the "Performance Threshold" will determine the payment adjustment.

Merit-Based Incentive Payment System (MIPS) (2018 Performance Year, 2020 Payment Year)



MIPS (2019 Performance Year, 2021 Payment Year – and Beyond)*



*Required by statute

MIPS Payment Adjustments

1. Quality Performance Category

- **Eligible clinicians will report selection of 6 individual measures or measures from "specialty measure sets" (available for certain specialties).**
- **Must include an outcome measure, and if not available then a "high priority" measure (appropriate use, patient safety, efficiency, patient experience, and care coordination measures).**
- **300 + individual measures to choose from; most measures from PQRS.**
- **Score for this category will be based on performance compared to a benchmark. In future years, score will also account for improvement.**

Quality Measure Examples

- **Individual Measures (CMS will continue annual call for new measures):**
  - **Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)**
  - **Diabetes: Medical Attention for Nephropathy**
  - **Diabetes: Foot Exam**
  - **Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy**
  - **Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation**
  - **Pneumonia Vaccination Status for Older Adults**
  - **Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed AND Risk-Stratified Fasting LDL-C**

- **Specialty Measure Sets (made up of a subset of individual measures):**
  - **Allergy/Immunology/Rheumatology**
  - **Cardiology**
  - **General Practice/Family Medicine**
  - **Internal Medicine**

- **Cross-Cutting Measures**
  - **Care Plan**
  - **Documentation of Current Medications in the Medical Record**
  - **Controlling: High Blood Pressure**
  - **Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**

2. Resource Use Performance Category

- **Costs based on Medicare beneficiaries <u>who are attributed to the clinician</u>.**
- **Includes "total cost per capita for all attributed beneficiaries" and "Medicare spending per beneficiary" (MSPB) measures from Value Modifier program.**
- **Episode-based measures still in development.**
- **No reporting requirement -- CMS calculates based on Medicare Part A and B claims (including Part B drug claims). <u>Part D claims may be included in future years.</u>**

3. Clinical Practice Improvement Activities (CPIA) Performance Category

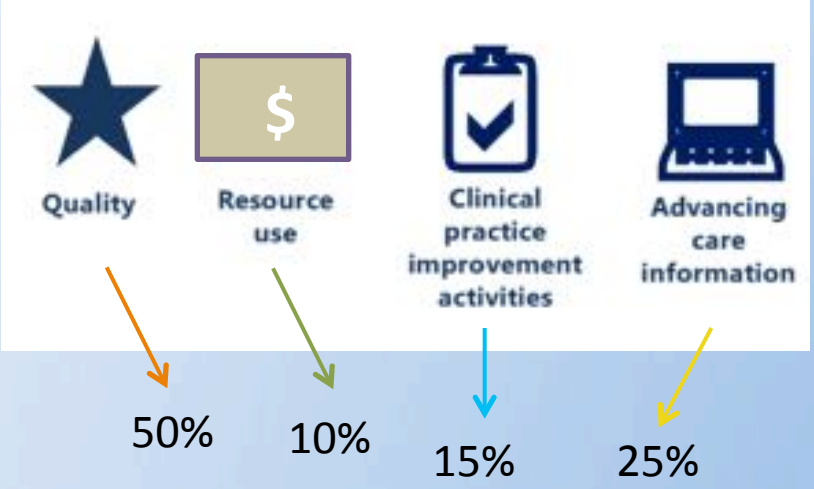
- **New category designed to incentivize activities that improve clinical practice or care delivery and that are likely to result in improved health outcomes.**
- **90+ proposed activities over 9 categories weighted either "high" or "medium".**
  - **<u>Examples</u>: population management for diabetics (high); evidence-based decision aids (medium)**
- **To achieve highest potential score, most clinicians must submit 2 high-weighted CPIAs or 4 medium-weighted CPIAs, or a combination.**
- **Full credit for patient-centered medical home participation; minimum of half credit for APM participation.**

4. Advancing Care Information Performance Category

- **Meaningful Use rebranded as "Advancing Care Information"**
- **ACI Performance Category score = base score + performance score + bonus point**
  - **Base score achieved for reporting all the measures for six objectives**
    - e.g. the Patient Electronic Access objective has two measures: Patient Access and Patient-Specific Education
  - **Performance score achieved based on performance rate (numerator/denominator) on 8 measures across specific 3 objectives (within the 6)**
  - **Bonus point for reporting one or more additional measures in the Public Health and Clinical Data Registry Reporting objective (Immunization Registry Reporting required)**

Calculating the Composite Performance Score

Scores from each performance category will be weighted and used to calculate CPS on a scale from 0 to 100.



ADVANCED APM PATHWAY

What is an Alternative Payment Model (APM)?

APMs are new approaches to paying for medical care through Medicare that are designed to incentivize quality and value.

As defined by MACRA, **APMs include:**

- ✓ **CMS Innovation Center model** (under Social Security Act § 1115A, other than a healthcare Innovation Award)
- ✓ **MSSP** (Medicare Shared Savings Program)
- ✓ **Demonstration** under the Health Care Quality Demonstration Program (Social Security Act § 1866C)
- ✓ **Demonstration** required by federal law

What is an Advanced APM?

As defined by MACRA, Advanced APMs **must meet the following criteria:**

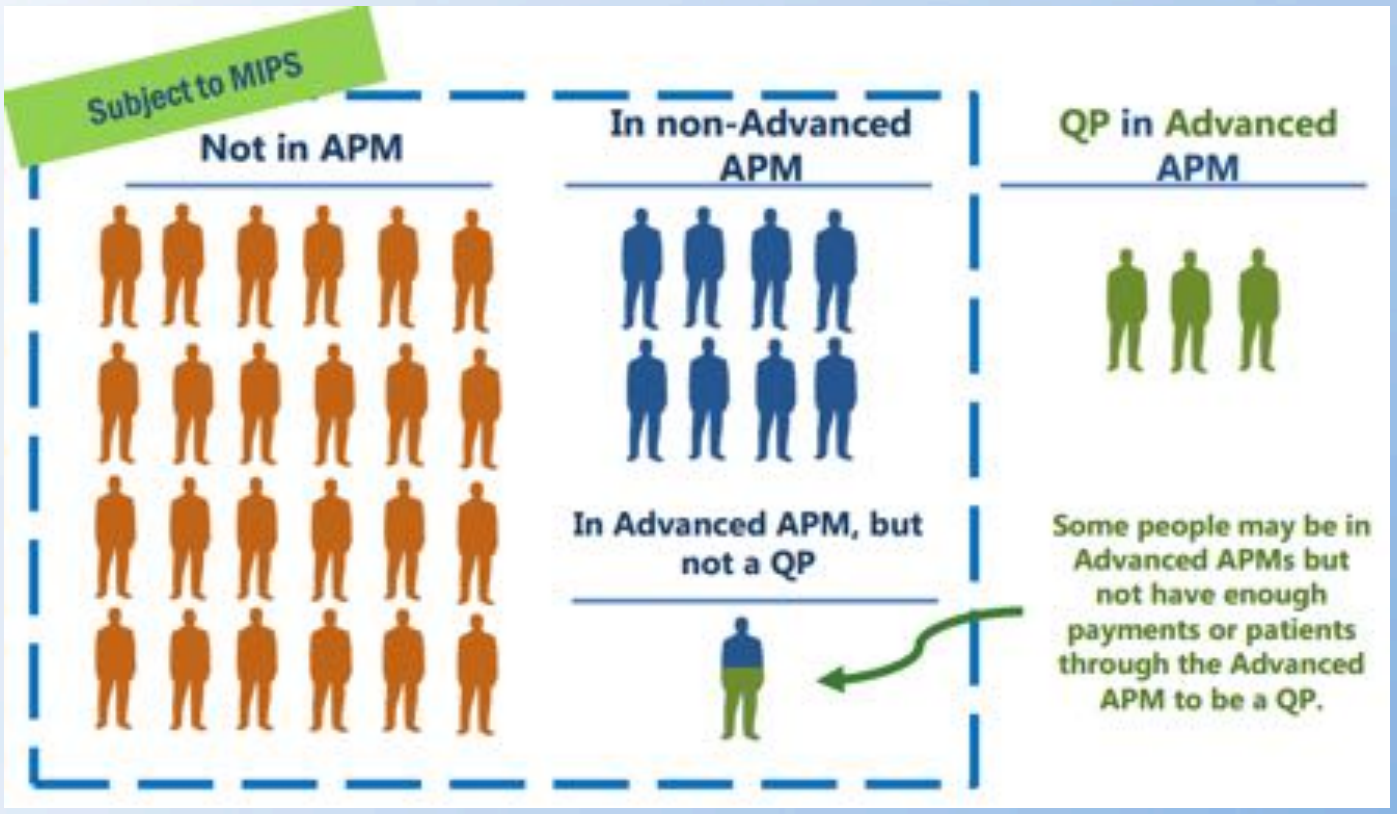
- ✓ The APM requires participants to use **certified EHR technology.**
- ✓ The APM **bases payment on quality** measures "comparable to" those in the MIPS quality performance category.
- ✓ The APM either: **(1)** requires APM Entities to bear more than nominal **financial risk** for monetary losses; **OR (2)** is a **Medical Home Model expanded** under CMMI authority.

What are the Current Advanced APMs?

Based on the proposed criteria, the following APMs will be Advanced APMs:

- ✓ **Medicare Accountable Care Organization (ACO) Track 1+ Model**
- ✓ **Shared Saving Program ACO** (Tracks 2 and 3)
- ✓ **Next Generation ACO Model**
- ✓ **Vermont Medicare ACO Initiative**
- ✓ **Comprehensive ESRD Care (CEC) Model** (LDO arrangement)
- ✓ **Comprehensive ESRD Care (CEC)** (non-LDO two-sided risk arrangement)
- ✓ **Comprehensive Primary Care Plus (CPC+) Model**
- ✓ **Oncology Care Model (OCM)**
- ✓ **Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1 – CEHRT)**
- ✓ **Bundled Payments for Care Improvement Advanced Model (BPCI Advanced)**

Must be a "Qualifying Participant" in an Advanced APM to be assigned to the Advanced APM Pathway



Qualifying Participants (QPs)

To qualify, clinicians must receive enough of their payments or see enough of their patients through an Advanced APM.

The participation requirements are specified in law and increase over time.

Significant Incentives to be a QP in Advanced APMs

- MACRA does not change how any particular APM functions or rewards value. Instead, it creates extra incentives for APM participation.
- For 2019-2024, all "qualifying APM participants" will be excluded from MIPS and will receive a lump-sum bonus of 5% of total Medicare Part B payments received in the prior year. Bonus payments stop after 2024.
- Beginning in 2026, qualifying APM participants will receive base Medicare Part B payments using a conversion factor that receives a higher annual update than the MIPS update (0.75% compared to 0.25%).
- CMS estimates that at most 10% of eligible clinicians will be assigned to the APM pathway in 2019. Longer-term outlook unclear. Depends partly on how stringent the final CMS criteria to be an "Advanced" APM.

Partial QPs: Almost, But Not Quite There

If clinician meets a **slightly reduced threshold** (% of patients or payments in an Advanced APM), he or she is considered a **"Partial Qualifying APM Participant" (Partial QP)** and can:

- Opt out of MIPS and receive no payment adjustment up or down; or
- Participate in MIPS and be subject to "MIPS AMP" Alternative Scoring (and receive a minimum CPIA category performance score of 50%).

QPP Payment Summary

QUESTIONS & DISCUSSION