MACRA in 2017 and Beyond

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NOTE

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Summary of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- Signed into law by President Obama on April 16, 2015
- Proposed Rule in April 2016; Final Rule in November 2016
- One of the most important piece of reimbursement-related legislation in decades
- Eliminates the sustainable growth rate (SGR) formula for physician updates to Medicare’s Physician Fee Schedule
- Quality Payment Program (QPP) takes the place of SGR, seeks to reward the delivery of high quality patient care through two avenues:
  - Merit-based incentive payment system (MIPS)
  - Advanced Alternative Payment Models (Advanced APMs)
The Path to MACRA

- **1980-1990**: Medicare payments to doctors were based on charges.
  - 13.4% annual growth rate
- Medicare was then reformed in 2 key ways:
  - creation of a fee schedule based on resources necessary to perform services;
  - annual increases restricted based on the total volume of services delivered
- **1997**: Budget deal introduced the Sustainable Growth Rate (SGR) which increased or decreased physician payments through a comparison with the GDP
  - Facing huge cuts, Congress passed "Doc fixes" to kick can down road
- **2006**: Physician Quality Reporting System (PQRS)
- **2009**: HITECH Act → Meaningful Use Program (MU)
- **2010**: Affordable Care Act → Value-based Modifier (VM)
Accountable Care Organizations (ACOs) under the Medicare Shared Savings Program

- Facilitates coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs.
- Providers band together and are responsible for assigned Medicare beneficiaries.
- CMS sets a benchmark for each ACO against which its performance is measured.
- ACOs that meet benchmark and satisfy quality performance standards are eligible to receive shared savings payment.
- Some ACOs require providers to be on the hook for shared losses.
- CMS' goal is to have more physicians take on downside risk, but as of January 2017, 91% of ACOs have no downside risk.
Quality Payment Program (QPP) in 2019:

- VM
- PQRS
- MU

- MIPS
- APM
Merit-Based Incentive Payment System (MIPS)

- Individual programs continue through 2018
- In 2019, payment is adjusted under MIPS
- Individual programs are reborn as MIPS performance categories
- Improvement Activities is a new category
- Cost is not factored in until 2018 performance year

<table>
<thead>
<tr>
<th>Quality</th>
<th>Improvement Activities</th>
<th>Advancing Care Information</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replaces PQRS.</td>
<td>New Category.</td>
<td>Replaces the Medicare EHR Incentive Program also known as Meaningful Use.</td>
<td>Replaces the Value-Based Modifier.</td>
</tr>
</tbody>
</table>
MIPS and Advanced APM Timeline

For providers participating in either MIPS or an Advanced APM, the cycle of the program works like this for the 2019 payment year:

- **Performance Year**: 2017
- **Submit**: March 31, 2018
- **Data Submission**:
- **Feedback Available**:
- **Adjustment**: January 1, 2019
  - Payment Adjustment
MIPS Eligible Clinicians

Affected clinicians are called "MIPS eligible clinicians" and will participate in MIPS. The types of Medicare Part B eligible clinicians affected by MIPS may expand in future years.

Years 1 and 2

Physicians, 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
Who will not participate in MIPS?

Clinicians who are:

- Newly-enrolled in Medicare
  - Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

- Below the low-volume threshold
  - Medicare Part B allowed charges less than or equal to $30,000 a year
    - OR
  - See 100 or fewer Medicare Part B patients a year

- Significantly participating in Advanced APMs
  - Receive 25% of your Medicare payments
    - OR
  - See 20% of your Medicare patients through an Advanced APM
Most Clinicians will be subject to MIPS
MIPS Performance Categories

- **Quality** *(Replaces PQRS)*
- **Cost** *(Replaces VM)*
- **Advancing Care Information** *(Replaces MU)*
- **Improvement Activities** *(New)*
MIPS: Quality Performance Category

- Replaces the Physician Quality Report System (PQRS)
- Quality of care is measured through evidence-based clinical quality measures (CQMs) that clinicians can select
- Clinicians choose to report on 6 measures, including at least 1 outcome measure
  - If outcome measure not available, report one other high priority measure
- If fewer than 6 measures apply to the clinician, report on each that is applicable
- Can select from individual or specialty measures
**MIPS: Quality Performance Category**

➤ **Example of a quality measure:**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>NOF/Quality #</th>
<th>CMS E-Measure ID</th>
<th>National Quality Strategy Domain</th>
<th>Data submission Method</th>
<th>Measure Type</th>
<th>Measure Title and Description</th>
<th>Primary Measure Steward</th>
</tr>
</thead>
<tbody>
<tr>
<td>§</td>
<td>0059/001</td>
<td>122 V5</td>
<td>Effective Clinical Care</td>
<td>Claims, Web Interface, Registry, EHR</td>
<td>Intermediate Outcome</td>
<td><strong>Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt;9%):</strong> Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c &gt; 9.0% during the measurement period.</td>
<td>National Committee for Quality Assurance</td>
</tr>
</tbody>
</table>
MIPS Performance Categories

- Quality *(Replaces PQRS)*

- **Cost** *(Replaces VM)*

- Advancing Care Information *(Replaces MU)*

- Improvement Activities *(New)*
MIPS: Cost Performance Category

- Replaces Value Modifier program
- Not included in calculation until 2018 performance year
- Compares resources used to treat similar care episodes and clinical condition groups
- Only analyzes costs for Medicare patients, and only for patients attributed to the specific clinician
- No reporting requirements. Calculated based on adjudicated claims
- Difference from VM: CMS adding 40+ episode specific measures to address specialty concerns
MIPS Performance Categories

- Quality *(Replaces PQRS)*

- Cost *(Replaces VM)*

- **Advancing Care Information** *(Replaces MU)*

- Improvement Activities *(New)*
MIPS: Advancing Care Information Performance Category

- Replaces Meaningful use Program
- Scoring based on key measures of health IT interoperability and information exchange
- Flexible scoring for all measures to promote care coordination for better patient outcomes

Key Changes from Current Program (EHR Incentive):
- Dropped “all or nothing” threshold for measurement
- Removed redundant measures to alleviate burden
- Reduced the number of required public health registries to which clinicians must report
MIPS Performance Categories

- Quality *(Replaces PQRS)*

- Cost *(Replaces VM)*

- Advancing Care Information *(Replaces MU)*

- Improvement Activities *(New)*
Rewards for activities focused on care coordination, beneficiary engagement, etc.

Each improvement activity is worth a certain number of points.

To not receive a zero score, a minimum selection of one activity (from 90+ proposed activities) with additional credit for more activities.

Full credit for patient-centered medical home.

Minimum of half of highest score for APM participation.
Clinicians and groups must submit measures, objectives, and activities for all categories except cost.

Individual eligible clinicians can submit through:

- A qualified registry for the quality, improvement activities, or ACI performance categories;
- The EHR submission mechanism for the quality, improvement activities, or ACI performance categories;
- A QCDR for the quality, improvement activities, or ACI performance categories;
- Medicare Part B claims for the quality performance category;
- Attestation for the improvement activities and ACI performance categories.
Pick Your Pace for Participation for 2017

Participate in an Advanced Alternative Payment Model

- Some practices may choose to participate in an Advanced Alternative Payment Model in 2017

MIPS

Test Pace
- Submit something
- Submit some data after January 1, 2017
- Neutral or small payment adjustment

Partial Year
- Submit a Partial Year
- Report for 90-day period after January 1, 2017
- Small positive payment adjustment

Full Year
- Submit a Full Year
- Fully participate starting January 1, 2017
- Modest positive payment adjustment

Not participating in the Quality Payment Program for the Transition Year will result in a negative 4% payment adjustment.
MIPS: Choosing to Test in 2017

- Submit minimum amount of 2017 data to Medicare
- Avoid a downward adjustment

You Have Asked: “What is a minimum amount of data?”

- OR
  - 1 Quality Measure
- OR
  - 1 Improvement Activity
- OR
  - 4 or 5 Required Advancing Care Information Measures
MIPS: Partial Participation in 2017

- Submit 90 days of 2017 data to Medicare
- May earn a positive payment adjustment

“So what?” - If you’re not ready on January 1, you can start anytime between January 1 and October 2

Need to send performance data by March 31, 2018
MIPS: Full Participation

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

Key Takeaway:
Positive adjustments are based on the performance data on the performance information submitted, not the amount of information or length of time submitted.
MIPS: Composite Scoring

- Scoring is based on the clinician's performance on measures and activities in the four performance categories.
- Clinicians are scored against performance standards for each performance category.
- Each category has a different weight.
- Final score of 0 to 100 points equal to the sum of each of the products of the performance category score and the category weight, multiplied by 100.
MIPS: Composite Scoring

Each of the four performance categories comprising MIPS will be scored under the following framework:

<table>
<thead>
<tr>
<th>Category</th>
<th>Scoring of Measures</th>
<th>Measured Against</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Performance</td>
<td>0-10 pts*; bonus</td>
<td>Benchmark based on historical performance</td>
</tr>
<tr>
<td>Cost</td>
<td>1-10 pts for each cost measure</td>
<td>Benchmark based on performance period</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>Points per activity</td>
<td>40 point total</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>Sum of base, performance and bonus scores</td>
<td>n/a</td>
</tr>
</tbody>
</table>

* For 2017 performance period, clinicians receive 3 to 10 points for measures in this category
MIPS: Composite Scoring, Weighting

The final score will be calculated using the following weights:

<table>
<thead>
<tr>
<th>Category</th>
<th>CY 2019</th>
<th>CY 2020</th>
<th>CY 2021 and beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
<td>50 %</td>
<td>30%</td>
</tr>
<tr>
<td>Cost</td>
<td>0%</td>
<td>10 %</td>
<td>30%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15 %</td>
<td>15 %</td>
<td>15 %</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25 %</td>
<td>25 %</td>
<td>25 %</td>
</tr>
</tbody>
</table>
MIPS: Payment Adjustment

- Clinicians final score compared to a threshold
- Reimbursement under Medicare Part B is adjusted based on where clinicians fall relative to the threshold
  - **At threshold** → No payment adjustment
  - **Above threshold** → Positive adjustment factor
    - Except if final score is not greater than \( \frac{1}{4} \) of the threshold
  - **Below threshold** → Negative adjustment factor
- Exceptional performers may receive additional positive adjustment
- These adjustments are in addition to planned increases in the physician fee schedule
MIPS: Payment Adjustment Limits

Adjusted Medicare Part B payment to clinician

The potential maximum adjustment % will increase each year from 2019 to 2022

Merit-Based Incentive Payment System (MIPS)

2019 2020 2021 2022 onward

+/-

Maximum Adjustments

+4% +5% +7% +9%

-4% -5% -7% -9%
Payment Adjustments Under MACRA

Fee Schedule:
- 2016: +0.5% each year
- 2017 to 2025: No change
- 2026 & on: +0.25% or 0.75%

MIPS:
- Max Adjustment (+/-):
  - 2016 to 2025: Various values (4, 5, 7, 9, 9, 9, 9)
- QP in Advanced APM: +5% bonus (excluded from MIPS)
Alternate Payment Models (APMs)

"Alternative Payment Model" used outside of MACRA to describe a payment model in which providers take responsibility for cost and quality performance and receive payments to support the services and activities designed to achieve high value.

MACRA has very specific definitions of:

- APM
- Advanced APM
- Other Payer Advanced APM
APMs under MACRA

• Under MACRA, APMs include any of the following:
  – a model under section 1115A of the Act (other than a health care innovation award);
  – the shared savings accountable care organization program under section 1899 of the Act;
  – a demonstration under section 1866C of the Act; or
  – a demonstration required by Federal law.

• But not all of these are "advanced"

• Only Advanced APMs are eligible for the APM bonus, higher increase in PFS, and MIPS exemption
Criteria for Advanced APM

• To be an Advanced APM, the APM must:
  • Be a CMS Innovation Center model, Shared Savings Program tracks, or certain federal demonstration programs
  • Require participants to use certified EHR technology
  • Base payments for services on quality measures comparable to those in MIPS
  • Be a Medical Home Model expanded under Innovation Center authority or require participants to bear risk…
Advanced APMs: Risk Standard

- APM must do one or more of the following:
  - Withhold payment for services to the APM Entity or its eligible clinicians
  - Reduce payment rates to the APM entity or its clinicians
  - Require the APM Entity to owe payments to CMS

- APM must take on at least the following amount of risk:
  - 3% of expected expenditures for which APM entity is responsible under the APM; or
  - 8% of estimated total Part A and B revenues of the APM entity.
Advanced APMs in 2017

In 2017, under the Quality Payment Program, clinicians may earn a 5 percent incentive payment through participation in the following Advanced APMs:

- Comprehensive ESRD Care Model (LDO arrangement)
- Comprehensive ESRD Care Model (non-LDO arrangement)
- CPC+
- Medicare Shared Savings Program ACOs—Track 2
- Medicare Shared Savings Program ACOs—Track 3
- Next Generation ACO Model
- Oncology Care Model OCM (two-sided risk arrangement)

We will publish a final list prior to January 1, 2017.
Advanced APMs in 2018

In 2018, we anticipate that clinicians may earn the incentive payment through participation in the following additional APMs:

- ACO Track 1+
- New Voluntary Bundled Payment Model
- Comprehensive Care for Joint Replacement Payment Model (CEHRT)
- Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

These lists will continue to change and grow as more models are proposed and developed in partnership with the clinician community and the Physician-Focused Payment Model Technical Advisory Committee.
Qualified APM Participants

- Only Qualified APM Participants (QPs) will receive the MIPS exclusion, 5% bonus payment and 0.75% bump in the PFS in 2026 and later.
- CMS will group all eligible physicians in an Advanced APM together and determine whether during a performance period, the eligible clinicians collectively have at least a specified percentage of:
  - aggregate Part B payments through the Advanced APM; or
  - patients receiving professional services through the Advanced APM.
- Beginning in 2019 (for 2021 payment year), CMS will calculate Medicare Advanced APM participation first; if QP status not reached, would consider all payer APMs.
# APM Participation Thresholds

## QP Payment Amount Thresholds

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<tr>
<th></th>
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<th>2021-2022</th>
<th>2023 and beyond</th>
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<tbody>
<tr>
<td><strong>Medicare Option</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QP</td>
<td>25%</td>
<td>50%</td>
<td>75%</td>
</tr>
<tr>
<td>Partial QP</td>
<td>20%</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>All-payer Option</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QP</td>
<td>N/A</td>
<td>25%</td>
<td>50%</td>
</tr>
<tr>
<td>Partial QP</td>
<td>N/A</td>
<td>20%</td>
<td>40%</td>
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</table>

## QP Patient Count Thresholds

<table>
<thead>
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<tr>
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<td>N/A</td>
<td>10%</td>
<td>35%</td>
</tr>
</tbody>
</table>

**Medicare** | **Total** | **Medicare** | **Total**

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*Note: N/A indicates data not available.*
Small Practice Assistance

- CMS is taking measures to assist solo, small and rural practices
- $100M / 5 years allocated to assist practices of ≤ 15, and those in rural and underserved areas
- Solo and small practices will be allowed to join “virtual groups” and combine their MIPS reporting. Not available for 2017 reporting.
- Eligible professionals will receive quality and cost measure feedback at least quarterly
MIPS: MIPS APMs

- Different scoring for those participating in an APM but which cannot participate in the APM track because the APM is not “advanced” or because they are not “qualified,” as discussed later.

- Removes duplicative reporting requirements.

- APM needs to base payment on cost/utilization and quality measures.

- MIPS eligible clinicians in APMs that require submission of quality not have to report quality under MIPS.

- Cost performance will have 0 weight since APM already accounts for cost.
Summary: Potential Financial Rewards

- **Not in APM**: MIPS adjustments
- **In APM**: MIPS adjustments + APM-specific rewards
- **In Advanced APM**: APM-specific rewards + 5% lump sum bonus

If you are a **Qualifying APM Participant (QP)**
Summary: Payment Adjustments

Fee Schedule

- 2016: +0.5% each year
- 2017: +0.5% each year
- 2018: +0.5% each year
- 2019: +0.5% each year
- 2020: No change
- 2021: No change
- 2022: No change
- 2023: No change
- 2024: No change
- 2025: No change
- 2026 & on: +0.25% or 0.75%

MIPS

- Max Adjustment (+/-)
- 2016: 4
- 2017: 5
- 2018: 7
- 2019: 9
- 2020: 9
- 2021: 9
- 2022: 9
- 2023: 9
- 2024: 9
- 2025: 9
- 2026 & on: 9

QP in Advanced APM

- +5% bonus (excluded from MIPS)