GNYHA/Premier MACRA Educational Series

Merit-Based Incentive Payment System (MIPS) Deep Dive

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Overview of MIPS Requirements

Medicare Access and CHIP Reauthorization Act of 2015

Created in 1997, the SGR capped Medicare physician spending per beneficiary at the growth in GDP

The formula does not incentivize high-quality, high-value care

Since 2003, Congress has passed 17 laws to override SGR cuts

SGR creates uncertainty and disruption for physicians and other providers

Most of $170B in 'patches' financed by health systems

On 3/26/15, the House passed H.R. 2 by 392-37 vote.

On 4/14/15, the Senate passed the House bill by a vote of 92-8, and the President signed the bill.

Election Result Implications for MACRA

- Top priority is to “repeal and replace” ACA
  - Use budget reconciliation process to repeal, with replacement to follow
  - May look more like a “rebrand and reboot”
  - Difficult to alter plan contracts for 2018, 2019 more likely
- Payment and delivery system reforms will remain
  - MACRA lives, and don’t mention the ACA
  - ACOs, bundled payments, other APMs continue
  - No new money, if anything cuts
  - Furtherance of quality and price transparency efforts
  - Readmissions, HACs and VBP stays, but with roll-up?
  - CMMI scope/budget possibly reduced or eliminated?

- More power will be shifted to the states regarding Medicaid and health coverage
  - Medicaid block granting/per capita payments
- Financial and pharmaceutical/device pricing pressures on providers will persist
- Trump’s HHS and other healthcare appointments will have tremendous impact on direction of changes that will be sought

Payment Cuts Across the Continuum of Care

Provider	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Inpatient Hospital	-3.50%	-3.60%	-4.15%	-2.95%	-3.15%	-2.20%	-2.20%	-2.10%	-2.10%	-2.60%
Outpatient Hospital	-2.70%	-2.80%	-3.35%	-2.45%	-2.65%	-1.50%	-1.60%	-1.50%	-1.60%	-2.10%
Physician	-2.30%	-3.70%	-3.80%	-3.80%	-3.40%	-3.60%	-4.20%	-4.20%	-4.40%	-4.40%
Skilled Nursing	-2.50%	-2.60%	-2.60%	-4.00%	-2.90%	-2.70%	-2.70%	-2.60%	-2.60%	-2.60%
Long Term Care Hospital	-2.70%	-2.80%	-3.35%	-4.00%	-3.65%	-2.70%	-2.70%	-2.60%	-2.60%	-2.60%
Inpatient Rehab Facility	-2.70%	-3.00%	-3.35%	-4.10%	-3.65%	-2.70%	-2.70%	-2.60%	-2.60%	-2.60%
Hospice	-2.80%	-3.10%	-2.90%	-4.10%	-3.20%	-2.70%	-2.70%	-2.60%	-2.60%	-2.60%
Home Health Care	-2.50%	-3.00%	-3.35%	-4.10%	-3.55%	-2.80%	-2.70%	-2.60%	-2.60%	-2.60%

- Includes maximum 2% sequestration reduction as well as ACA, ATRA, and MACRA mandated reductions. For operational purposes, sequestration is applied to payment last

New Healthcare Leaders in Trump Administration

DEPARTMENT OF HEALTH AND HUMAN SERVICES SECRETARY

NOMINEE:
TOM PRICE

- Orthopedic surgeon
- Current House Budget Committee Chairman & House Ways & Means Health Subcommittee member (R-GA)
- ACA critic and first to put forward replacement plan (Empowering Patients First Act)
  - Age-adjusted tax credits to help people buy insurance & increased reliance HSAs and high-risk pools at the state level
  - Allow opt out of Medicare, Medicaid or VA benefits and receive the tax credit to buy individual plan
- Supported MACRA, but has called into question some of its implementation, including physician reporting requirements
- Critic of CMMI under Obama Administration, but main opposition is with mandatory programs
- Strong supporter of state government proposals of how to spend their healthcare dollars
- CJR, EPM and MSSP Track 1.5??????

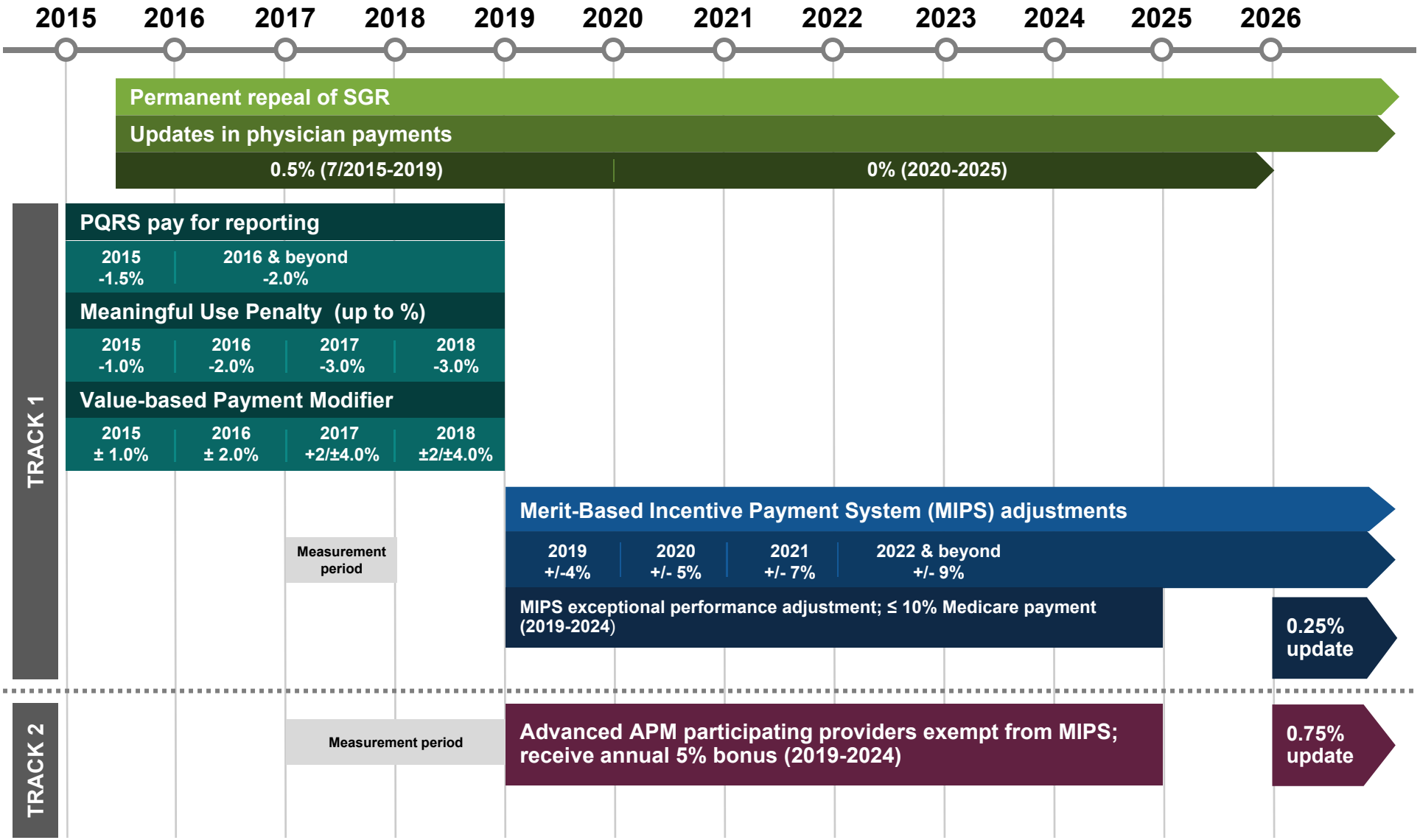
New Healthcare Leaders in Trump Administration

CENTERS FOR MEDICARE & MEDICAID SERVICES ADMINISTRATOR

NOMINEE:
SEEMA VERMA

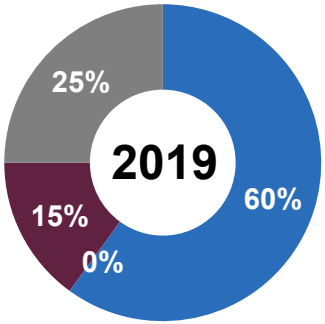
- President and founder of SVC, Inc., a national health policy consulting company located in Indiana
- Architect of Healthy Indiana Plan (HIP), the nation's first consumer-directed Medicaid program under IN Governor Daniels and Governor Pence's HIP 2.0 waiver proposal
- Developed IA and OH 1115 Medicaid waiver, assisted with design of TN's coverage expansion proposal, and provided technical assistance to MI's implementation of 1115 Medicaid waiver
- Former VP of Planning for Health & Hospital Corporation of Marion County and Director with the Association of State and Territorial Health Officials (ASTHO) in Washington D.C
- MA in Public Health w/ concentration in health policy and management from Johns Hopkins University and BS in Life Sciences from the University of Maryland

MACRA Reform Timeline
(Medicare Access and CHIP Reauthorization Act of 2015)

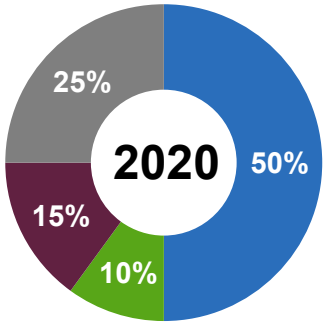


Merit-based Incentive Payment System (MIPS)

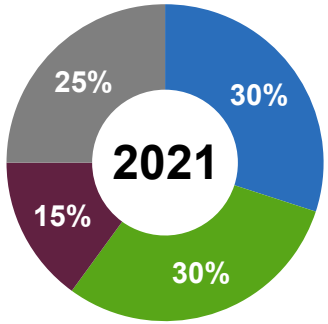
MIPS Overview



Any continuous 90-days in CY 2017 is performance period for CY 2019

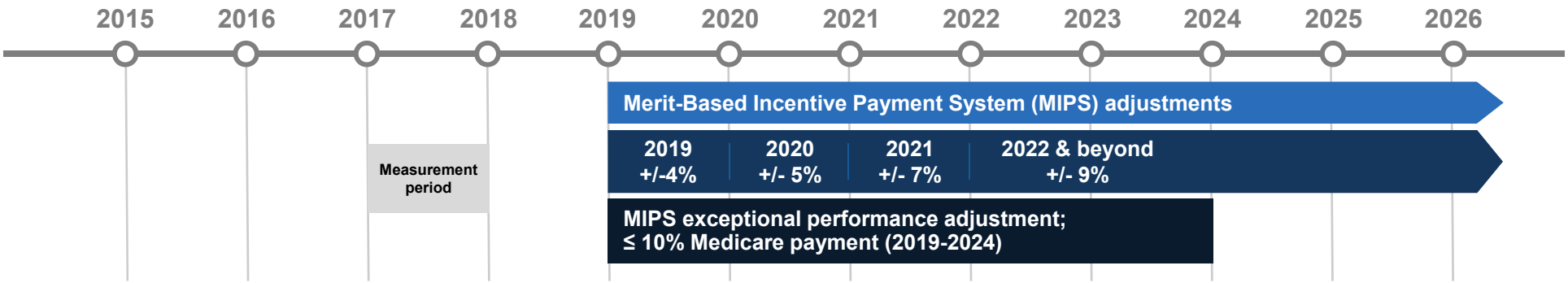


CY 2018 is performance period for CY 2020. Cost/quality- Full year; ACI/Improvement- any 90 days



- **Quality** — PQRS Measures, Readmissions
- **Cost** — MSPB, Total Per Capita Cost, Episode Payment
- **Advancing care information** — Modified Meaningful Use Objectives & Measures
- **Improvement activities** — Expanded access, population management, care coordination, beneficiary engagement, patient safety, social and community involvement, health equity, emergency preparedness, behavioral and mental health integration and Alternative payment models.

- **Sets performance targets in advance, when feasible**
- **Sets performance threshold at 3; median or mean in later years.**
- **Improvement scores in later years**



MIPS: 2019 Payment Year / 2017 Performance Year

Advancing care information: 100 points

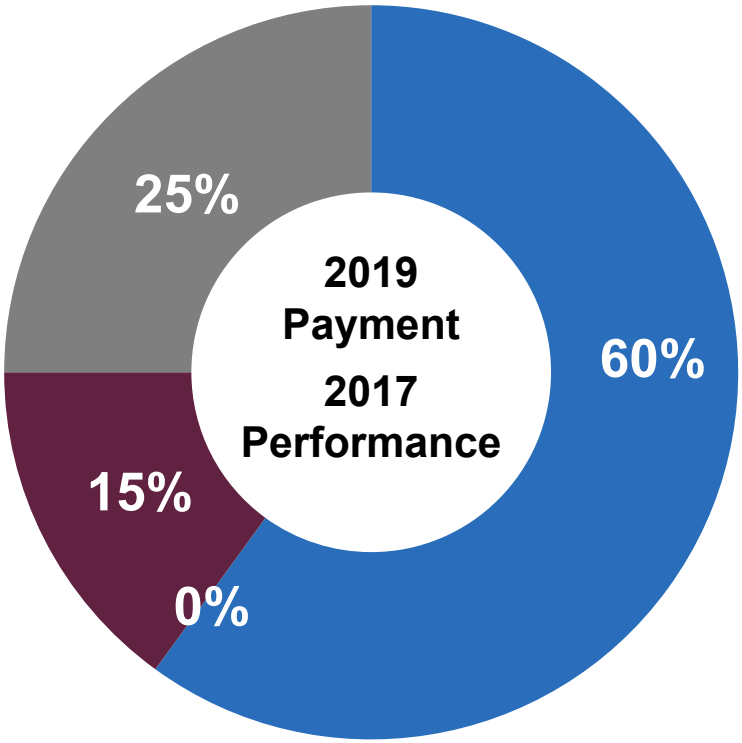
Base Score
- Security Risk Analysis
- eRx
- Provide patient access
- Send summary of care
- Receive summary of care

Performance Score
Bonus Points

Improvement activities: 40 points

High Weight: 20 points
Medium Weigh: 10 points

PCMH: 40 points
APM Participation:
At least 20 points



Quality: 60 points*

6 measures (one outcome) Readmissions (groups of 16+ only)

Bonus points:
- Outcome, appropriate use, patient safety, patient experience, care coordination measures
- Report measures using end-to-end reporting

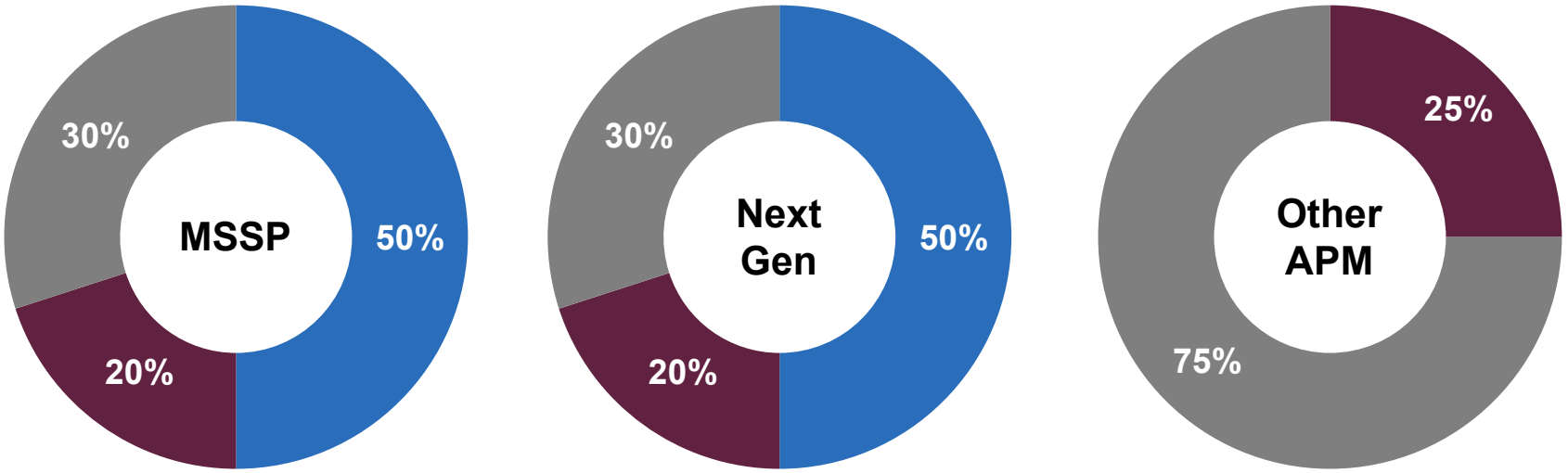
3-point floor: Report measure data that cannot be scored and avoid payment adjustment

Cost:
Not Assessed- Feedback Reports Only

MSPB, Total Per Capita Cost, Episode Payment

*Total points possible vary by provider type and available measures

MIPS: APM Scoring Standard



Quality — Measures reported by APM

Web Interface measures: 14 measures, 4 receive a bonus point • 2017: 11 measures

Cost — Not assessed

Advancing care information — Average of individual clinicians submitting as individuals or groups

MSSP: Weighted average of score for TINs

Improvement activities — Automatically receive half of the points

Models awarded full points: Shared Savings, Next Gen, Comprehensive ESRD Care (all arrangements), Oncology Care Model (all arrangements), CPC+

MIPS: Performance Periods

- CY 2019 Payment
  - January 1, 2017- December 31, 2017
  - Any continuous 90 days for all categories/reporting options
    - » except CAHPS, Web Interface, Readmissions
  - May elect to report more than a minimum 90-day period
  - 90-day reporting periods can vary for each performance category
- CY 2020 Payment
  - January 1, 2018- December 31, 2018
  - Cost and quality: 1 year
  - ACI and improvement activities: any continuous 90-days
- CY 2021 Payment and Subsequent Years
  - TBD

MIPS: Eligible Clinicians

Years 1 and 2

- Physician,
- Physician Assistants,
- Nurse Practitioners,
- Certified-Nurse Specialists,
- Certified Registered Nurse Anesthetists

Years 3+

- Physical or occupational therapist,
- Speech-language pathologists,
- Audiologists,
- Nurse midwives,
- Clinical social workers,
- Clinical psychologists,
- Dieticians,
- Nutritional professionals

- Exclusions
  - New Medicare-enrolled eligible clinicians
    - » Enrolled during the performance year
    - » Not previously part of a group or billing under a different TIN
    - » Eligibility determined quarterly
  - Clinicians below the low-volume threshold
    - » $30,000 or less in charges **OR**
    - » Provides care to 100 beneficiaries or fewer
  - Qualifying/ Partial Qualifying Advanced APM Participants

- Non-Patient Facing MIPS ECs
  - Individuals: bill 100 or fewer patient-facing encounters
  - Groups: More than 75% of NPIs under the TIN meet the individual threshold
  - Non patient-facing determination made in two-segment claims analysis
- CAHs: MIPS adjustment applies
- RHC/FQHC: MIPS adjustment does not apply

Projected Number of Clinicians Ineligible for or Excluded from MIPS in CY 2017, by Reason*

Reason for Exclusion	Medicare Clinicians(TIN/NPIs)	Part B Allowed Charges (mil)
All	738,090 – 788,090	$23,314 - $28,076
Qualifying APM Participants**	70,000 lower bound 120,000 upper bound	$6,666 - $11,428
Ineligible Specialties***	199,308	$10,614
Newly-enrolled clinicians****	85,268	$1,283
Low-volume clinicians*****	383,514	$4,751

*Allowed charges for covered services of the clinician under Part B.

2015 data used to estimate 2017 performance. Payments estimated using 2015 dollars.

**QPs have at least 25 percent of their Medicare Part B covered professional services or least 20 percent of their Medicare beneficiaries furnished part B covered professional services through an Advanced APM. The upper bound estimate for QPs also reflects that a small number of Advanced APM participants may be Partial Qualifying APM Participants (Partial QPs) that opt to be excluded from MIPS. For MIPS Year 1, Partial QPs are APM participants that have at least 20 percent, but less than 25 percent, of their Medicare Part B covered professional services through an Advanced APM Entity, or at least 10 percent, but less than 20 percent, of their Medicare beneficiaries furnished part B covered professional services through an Advanced APM Entity.

***Section 1848(q)(1)(C) of the Act defines a MIPS eligible clinician for payment years 1 and 2 as a physician, physician's assistant, nurse practitioner, or clinical nurse anesthetist, or a group that includes such clinicians.(See section II.E.1 for further details) Our estimates of ineligible clinician types count clinician types who received part B payments but are not listed as eligible clinicians in the Act for payment year 1 or 2.

****Newly enrolled Medicare clinicians in our data had allowed PFS charges in CY 2015 but the NPI did not have allowed PFS charges in CY 2014.

*****Low-volume clinicians have less than or equal to $30,000 in allowed Medicare Part B charges or less than or equal to 100 Medicare patients

MIPS: Identifiers

- Individual- TIN/NPI
- Group- TIN
  - 2 or more MIPS ECs who have assigned billing rights to TIN
  - Small group: 15 or fewer ECs in the group
  - Must meet group definition during performance period
  - Data must be aggregated across the group
    - » Can't split TIN for reporting purposes (excluded ECs are in)
    - » Payment adjustment only applies to eligible ECs
      - QP/Partial QP or newly enrolled will not receive payment adjustment
  - Must be assessed as a group across all four categories
  - No virtual groups for the 1st performance year (seek additional comments)
  - Registration required for Web Interface and CAHPS; considering voluntary registration for all other reporting options (sub regulatory guidance)
- APM Participant Identifier
  - APM ID
  - APM Entity ID
  - TIN/NPI

MIPS: Reporting Mechanisms

Reporting Mechanism	Quality+	Cost	ACI	IA+	Submission Deadline
Claims	✓ Individual only				60-day claims lag
Administrative Claims (no submission required)	✓ Readmissions only	✓			
Attestation			✓	✓	March 31 of year following performance period close
QCDR	✓+		✓	✓	
Qualified Registry	✓+		✓	✓	
EHR	✓+		✓	✓	
CMS Web Interface	✓+ Option for groups 25+		Option for groups 25+	Option for groups 25+	8 weeks following performance period close
Survey Vendor	Groups choosing to report CAHPS for MIPS				

+ Bonus points possible

MIPS: Quality Performance Category (60%)

Part B Claims	QCDR, Registry, EHR	CMS Web Interface	CAHPS (optional)
▪ 90-day reporting period; One year in 2018 ▪ 6 measures (1 outcome) ▪ Report on 50% of all Part B patients seen to which the measure applies	▪ 90-day reporting period; One year in 2018 ▪ 6 measures (1 outcome) ▪ Report on 50% of all patients seen (all payer) to which measure applies	▪ One year reporting period ▪ Groups 25+only ▪ 11 measure (14 measures in 2018) ▪ Sampling requirements for Part B beneficiaries	▪ One year reporting period ▪ Counts as 1 of 6 required measures ▪ Sampling requirements for Part B beneficiaries

- Global and Population Based Measures
  - All Cause Hospital Readmission Measure (Groups 16+ with case size of 200+)
  - Did not finalize inclusion of AHRQ Prevention Quality Indicators– Acute Composite and Chronic Composite
- MIPS Measures: Tables A, B, D, E, and G
- Non-MIPS measures approved for use in QCDRs

MIPS: Quality Performance Category (60%)

Measure Scoring

- No successful reporting requirements, each measure submitted is awarded points based on decile breaks
- Topped out measure policy does not apply until year 2 of measure being topped out (2018 performance period is earliest)
- Transition Year Policy
  - Class 1 measure: 3-10 points
    - » Has a benchmark
    - » At least 20 cases
    - » Meet data completeness standard
  - Class 2 measure: 3 points
    - » Does not have a benchmark
    - » Does not have at least 20 cases
    - » Does not meet data completeness standard

Bonus Points

- High Priority Measures (up to 10% of total possible score)
  - 2 points for each outcome and patient experience measure (excludes required outcome measure)
  - 1 point for each high priority measure (patient safety, efficiency, appropriate use, care coordination)
- End to End Reporting (up to 10% of total possible score)
  - 1 point for each measure
  - CEHRT is used to record measures demographic and clinical information
  - Measure data is electronically submitted to 3rd party intermediary (e.g. QCDR)
  - 3rd party intermediary calculates and submits data electronically to CMS

MIPS: Quality Benchmarks

- Baseline period is two years prior (2015 for 2017 reporting)
- Each benchmark must have 20 MIPS eligible clinicians meeting data completeness
- New measure benchmarks derived from performance period (2017 for CY 2019 payment) and have 3-point floor
- Separate benchmarks for each reporting mechanism
- Web Interface benchmarks same as MSSP

Decile	Sample Quality Measure Benchmarks	Possible Points with 3-Point Floor	Possible Points without 3-Point Floor
Benchmark Decile 1	0-9.5%	3.0	1.0-1.9
Benchmark Decile 2	9.6-15.7%	3.0	2.0-2.9
Benchmark Decile 3	15.8-22.9%	3.0- 3.9	3.0-3.9
Benchmark Decile 4	23.0-35.9%	4.0-4.9	4.0-4.9
Benchmark Decile 5	36.0-40.9%	5.0-5.9	5.0-5.9
Benchmark Decile 6	41.0-61.9%	6.0-6.9	6.0-6.9
Benchmark Decile 7	62.0-68.9%	7.0-7.9	7.0-7.9
Benchmark Decile 8	69.0-78.9%	8.0-8.9	8.0-8.9
Benchmark Decile 9	79.0-84.9%	9.0-9.9	9.0-9.9
Benchmark Decile 10	85.0%-100%	10	10

MIPS: Cost Performance Category

- 2017 (2019 payment)- 0% Feedback Reports Provided
- 2018 (2020 payment) 10%
- 2019 (2021 payment) and later- 30%

Measure	Description
Medicare Spending per Beneficiary	▪ Attribution: TIN providing plurality of Medicare Part B claims ▪ Evaluate observed to expected costs at the episode level ▪ Measure is average of assigned ratios ▪ 35 minimum cases
Total per Capita Cost	▪ Attribution: Two-step process: ▪ TIN of PCP providing plurality of primary care services ▪ TIN of Non-PCP providing plurality of primary care services ▪ 20 minimum cases
10 Episode-based payment measures	▪ 20 minimum cases ▪ Included in 2014 and 2015 sQRUR and reliability of 0.4 for majority of clinicians ▪ Acute condition: All MIPS eligible clinicians that bill at least 30% of inpatient E&M visits during trigger event; more than one clinician can be attributed ▪ Procedural: MIPS eligible clinicians billing a part B claim with a trigger code during the trigger event – Inpatient- inpatient stay triggering the episode plus day prior to admission – Outpatient Method A- day before triggering claim- two days after triggering event – Outpatient Method B- day of triggering event

MIPS: Cost Episode-Based Payment Measures

- Method A
  - Mastectomy
  - Aortic/Mitral Valve Surgery
  - Coronary Artery Bypass Graft
  - Hip/Femur Fracture Dislocation, Treatment, Inpatient-Based
- Method B
  - Cholecystectomy and Common Duct Exploration
  - Colonoscopy and Biopsy
  - Transurethral Resection of the Prostate for Benign Prostatic Hyperplasia
  - Lens and Cataract Procedures
  - Hip Replacement or Repair
  - Knee Arthroplasty

MIPS: Improvement Activity Performance Category (15%)

Conduct Improvement Activities

- High-weighted: 20 points
- Medium-weighted: 10 points
- Small practice, rural, HPSA, non-patient facing: 20 points earns full credit

CMS Improvement Activities and Measurement Study

- Selected participants receive 40 points

Patient-Centered Medical Home Recognition

- Receive 40 points
- Patient-centered medical home or comparable specialty practice recognition
- Certification or recognition from a national program, regional/state program, or private payer that certifies at least 500 or more practices
- Examples of nationally recognized programs: Joint Commission, NCQA, URAC

APM Participation

- Receive at least 20 points
- On an APM Entity Participant List
- CMS will evaluate each MIPS APM model against improvement activities to determine if more points are awarded
- **For FY 2017 performance, all current models receive full credit**

MIPS: Improvement Activities – High Weighted and ACI Bonus

High Weight	ACI Bonus	Subcategory	Activity (abbreviated)
X	X	Expanded Practice Access	Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record
X		Population Management	Anticoagulant management program
X	X		Anticoagulant management improvements
X			Participating in RHC, HIS, or QHC that participate in quality reporting
X	X		Diabetes management program that accounts for patient—specific factors
X			Use of a QCDR to generate feedback that summarizes patterns and outcomes
	X		Managed chronic and preventive care for empaneled patients
	X		Longitudinal care management to high risk patients
	X		Episodic care management across transitions and referrals
	X		Manage medications to maximize efficiency
	X	Care Coordination	Care coordination practices like reports to specialists, closing referral loop
X			Participation in CMS Transforming Clinical Practice Initiative
	X		Documentation of care coordination processes
	X		Develop regularly updated care plans
	X		Bilateral exchange of patient information

MIPS: Improvement Activities – High Weighted and ACI Bonus

High Weight	ACI Bonus	Subcategory	Activity (abbreviated)
	X	Beneficiary Engagement	Capture of patient reported outcomes
	X		Access to enhanced patient portal
X			Collection and follow-up on patient experience and satisfaction data
	X		Engage patients and families to guide improvement in care
	X		Provide self-management materials at appropriate literacy level
X		Patient Safety	Consultation of prescription drug monitoring
X			Participation in CAHPS
	X		Use decision support and standard treatment protocols
X			Seeing new and follow-up Medicaid patients in a timely manner
	X	Health Equity	Participation in a QCDR that screens for social determinants of health
X		Emergency Response	Domestic or international humanitarian volunteer work
X		Behavioral Health	Integration facilitation/colocation of mental health and substance abuse services with primary care
X	X		Integrated behavioral health services
	X		EHR capture of behavioral health data for decision-making purposes

MIPS: Advancing Care Information Performance Category (25%)

Base Score (50 points)

- Security Risk Analysis
- eRX
- Provide Patient Access
- Send a Summary of Care
- Request/Accept Summary of Care

+

Performance Score (up to 90 points)

- Provide Patient Access
- Patient-Specific Education
- View, Download or Transmit
- Secure Messaging
- Patient-Generated Health Data
- Send a Summary of Care
- Clinical Information Reconciliation
- Immunization Registry Reporting

+

Bonus Points (up to 15 points)

- Optional Registry Reporting (5 points)
- Improvement Activities Using CEHRT (10 points)

=

Total Score

- 155 possible points
- Scored out of 100 points

- Category is not scored for certain clinicians
  - Hospital-based clinicians- more than 75% of care furnished in an inpatient hospital, on campus outpatient hospital or ED
  - Hardship Exemption
  - NP, PA, CNS, CRNA- must submit application by March 31, 2018

MIPS: Advancing Care Information (ACI) Performance Category (25%)

- Formerly Medicare EHR Incentive Program (meaningful use)
- Total Possible Score of 100 points
- Definitions
  - Certified health IT- technology and systems certified under ONC Health IT Certification Programs
  - Certified health IT module- a technology or function used independently of an EHR
  - Certified EHR Technology- technology used by MIPS eligible clinicians and participants in APMs
  - Meaningful User- a MIPS eligible clinician who possesses certified EHR technology, uses the functionality of certified EHR technology, and reports on applicable objectives and measures specified for the advancing care information performance category

MIPS: ACI CEHRT Version

- 2017- MIPS Eligible Clinician can use technology certified to 2015 or 2014 Edition
  - 2015 Edition: Stage 3 or modified Stage 2
  - Combination of 2015 and 2014 Edition: Stage 3 or modified Stage 2
  - 2014 Edition: Modified Stage 2
- 2018: Must use technology certified to 2015 Edition and report Stage 3 objectives and measures
- Reporting of objectives and measures at the group level
  - If unable to produce group rates, can aggregated each NPI rates
  - If aggregating NPI rates, a patient can occur in the denominator more than once

MIPS: ACI Scoring Stage 3 Objectives and Measures

Objective	Measure	Base Score (50%) Requirement	Performance Score (up to 90%)
Protect Patient Health Information	Security Risk Analysis MUST PASS	☑ Must attest "yes"	0
Electronic Prescribing	ePrescribing	☑	0
Patient Electronic Access	Provide Patient Access ★	☑	Up to 10%
	Patient-Specific Education★		Up to 10%
Coordination of Care Through Patient Engagement	View, Download or Transmit (VDT) ★		Up to 10%
	Secure Messaging★		Up to 10%
	Patient-Generated Health Data★		Up to 10%
Health Information Exchange	Send a Summary of Care★	☑	Up to 10%
	Request/Accept Summary of Care★	☑	Up to 10%
	Clinical Information Reconciliation★		Up to 10%
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting★		0 or 10%
BONUS	Syndromic Surveillance Reporting★	Bonus	5%
	Electronic Case Reporting		
	Public Health Registry Reporting		
	Clinical Data Registry Reporting		
	Improvement Activities Using CEHRT	Bonus	10%

MIPS: ACI Scoring Modified Stage 2 Objectives and Measures

Objective	Measure	Base Score Requirement	Performance Score/ Bonus
Protect Patient Health Information	Security Risk Analysis MUST PASS	☑ Must attest "yes"	0
Electronic Prescribing	ePrescribing	☑	0
Patient Electronic Access	Patient Access ★	☑	Up to 20%
	View, Download or Transmit (VDT) ★		Up to 10%
Patient-Specific Education	Patient-Specific Education★		Up to 10%
Secure Messaging	Secure Messaging★		Up to 10%
Health Information Exchange	Health Information Exchange★	☑	Up to 20%
	Medication Reconciliation★		Up to 10%
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting		0 or 10%
BONUS	Syndromic Surveillance Reporting	Bonus	5%
	Specialized Registry Reporting		
	Improvement Activities using CEHRT	Bonus	10%

MIPS: Payment Adjustment for 2019

Applied to Part B payments at TIN/NPI level

-4%

FAIL TO REPORT
-4% adjustment

0%

SUBMIT MINIMAL DATA

+0-4%

SUBMIT SOME BUT NOT ALL DATA

+0.5-10%

SUMBIT 90-DAY TO FULL CALENDAR DATA
Receive a small positive payment adjustment: 0.5-10%

← TEST PARTICIPATING IN MIPS →

Final Score	How to Achieve Score	MIPS Adjustment
0- 0.75	Fail to Report	Negative 4%
0.76- 2.69	Unlikely to occur	-4 to 0%
3.0	Submit 1 quality measure that does not meet data completeness standards Submit 1 low-weighted improvement activity	0%
3.1- 69.9	Submit additional information to full reporting with low performance	0-4% x scaling factor
70.0- 100	Fully participate with high performance	0-4% x scaling factor AND MIPS exceptional performance adjustment 0.5%- 10% x scaling factor

MIPS: Feedback, Review and Corrections

- Feedback
  - 2015 performance QRURs and sQRURs available now
  - 2016 performance QRURs expected fall 2017
  - MIPS data provided annually, first year data not available until 2018
  - Targeted Review: Must submit request within 60 days of CMS providing MIPS adjustment factors; 30 days to respond to CMS information requests
- MIPS Adjustment Announcement: By December 1, 2018
- Data Validation and Auditing
  - Selectively audit eligible clinicians yearly
    - » Must respond to requests in 45 business days
    - » Must provide primary source documents as requested
  - Establishes rules for recouping any over payments made as a result of inaccurate data
  - Clinicians must attest to accuracy and completeness of data

MIPS: Public Reporting on Physician Compare

- For each MIPS eligible clinician, final score and performance by category
- Subsets of detailed information for each performance category
  - Quality: rates for measures determined suitable for public reporting (minimum sample size of 20)
  - Cost: measures to be determined
  - Improvement activities: to be determined based on consumer and statistical testing
  - ACI: Indicator for clinicians successfully meeting this category
- Aggregate information on range of scores
- Participation in Advanced APM with links to APM data

Proposed Rule Impact Analysis

Solo and small practices will get hit hardest under the new incentive payment system

Practice size	Eligible clinicians	Percentage likely to be penalized	Percentage likely to get bonus
Solo	102,788	87%	12.9%
2-9	123,695	69.9%	29.8%
10-24	81,207	59.4%	40.3%
25-99	147,976	44.9%	54.5%
100 or more	305,676	18.3%	81.3%
Overall	761,342	45.5%	54.1%

Source: CMS

MIPS Final Rule Estimated Impact on Total Allowed Charges by Practice Size (Y2019), Standard Participation Assumptions

Practice Size	Eligible Clinicians	Physician Fee Schedule Allowed Charges (mil)	Percent Eligible Clinicians with Positive or Neutral Adjustment	Percent Eligible Clinicians with Negative Adjustment	Aggregate Impact Positive Adjustment (mil)	Aggregate Impact Negative Adjustment (mil)	Net Impact of MIPS Payment Adjustment (mil)
1-9	147,739	$30,426	90.0%	10.0%	$244	-$99	$145
10-24	63,829	$10,870	90.0%	10.0%	$80	-$37	$42
25-99	132,406	$13,942	92.6%	7.4%	$101	-$47	$54
100+	332,748	$23,216	98.5%	1.5%	$274	-$16	$258
Overall	676,722	$78,454	94.7%	5.3%	$699	-$199	$500

Practice size is the total number of MIPS eligible TIN/NPIs in a TIN.

Standard scoring model assumes that a minimum of 90 percent of clinicians within each practice size category would participate in quality data submission.

*2015 data used to estimate 2017 performance. Payments estimated using 2015 dollars.

**The Net Impact to Payments is the combined impact of negative and positive MIPS payment adjustments and the exceptional performance payment.

***The estimated number of MIPS eligible clinicians subject to reporting requirements are based on QP eligibility model estimates. The number of clinicians in the scoring model exceeded the upper bound estimate of MIPS eligible clinicians due to discrepancies between scoring model data on QPs and QP eligibility model estimates.

****Specialty descriptions as self-reported in the National Plan and Provider Enumeration System (NPPES) at the time of issuance of a National Provider Identifier (NPI). Note that all categories are mutually exclusive, including General Practice and Family Practice. ‘Family Medicine’ is used here for physicians listed as ‘Family Practice’ in NPPES

Advance Alternative Payment Model (APM) Incentive

Estimated Participation in Advanced APMs

- Proposed rule estimated 30,000 to 90,000 clinicians would be excluded from MIPS as QPs in Advanced APMs in 2017
- Final rule estimates between 70,000 and 120,000 clinicians excluded from MIPS as QPs in Advanced APMs in 2017
  - Approximately 5-8 percent of all clinicians billing under Medicare Part B
- Incentive payments for QPs expected to total between $333M and $571M in 2019 (2017 performance)
- Also estimates 125,000 to 250,000 clinicians excluded from MIPS as QPs in Advanced APMs in 2018

Advanced APM Step 3: Are You an Eligible Clinician in the Advanced APM Entity?

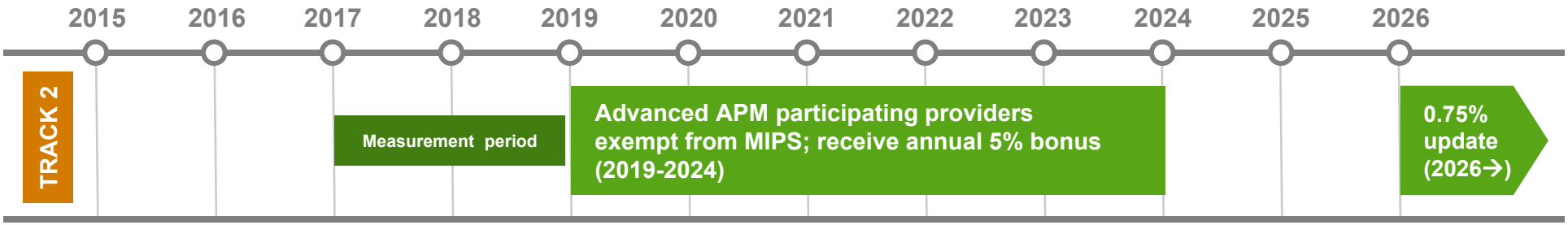
Types of Eligible Professionals	Track 1		Track 2
	Value-Modifier	MIPS	APM
Medicare Physicians: Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Oral Surgery, Doctor of Dental Medicine, Doctor of Chiropractic	2017 (2015 performance)	2019	2019
Practitioners: Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist	2018 (2016 performance)	2019	2019
Practitioners: Certified Nurse Midwife, Clinical Social Worker, Clinical Psychologist, Registered Dietician, Nutrition Professional, Audiologists	N/A	2021	2019
Therapists: Physical Therapist, Occupational Therapist, Qualified Speech-Language Therapist	N/A	2021	2019

Exclusions: New Medicare-enrolled eligible clinicians; Clinicians below the low-volume threshold

Track 2: 5% Bonus for Advanced APMs

Advanced Alternative Payment Models (APM) as proposed:

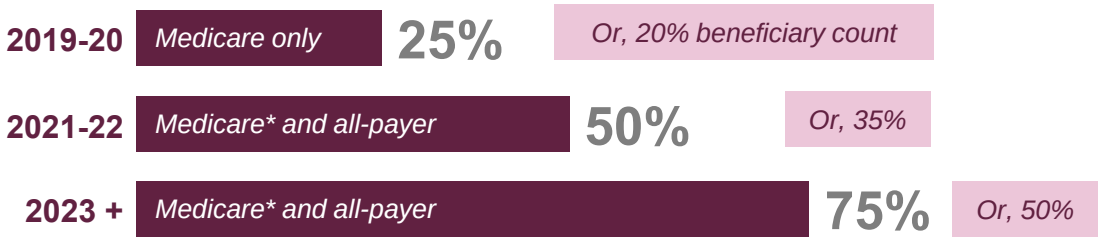
Comprehensive ESRD (2-sided risk)	Medicare Shared Saving Program (Tracks 2 & 3)	Next Generation ACO	Oncology Care Model (2-sided risk)	Comprehensive Primary Care Plus	Comprehensive Care for Joint Replacement	Episode Payment Models
	Track 1+ coming soon	Application open for 2018	Risk Track now open in 2017	Re-open in 2018	2017	2018



Advanced Alternative Payment Models (APM) Entities Must:

1. Uses certified EHR technology,
2. Pays based on MIPS comparable quality measures, *and*
3. Bears more than "nominal" financial risk for losses.

Inclusion in Advanced APMs triggers exclusion from MIPS.



Threshold of payments in an Advanced APM

- Total payments exclude payments made by the Secretaries of Defense/Veterans Affairs and Medicaid payments in states without medical home programs or Medicaid APMs.

* Minimum of 25% of Medicare payments must be in APM in all years, unless partial qualifying at with no 5% bonus and a choice of MIPS

Important Links

Premier Resources

- https://learn.premierinc.com
- Premier detailed summary
- Premier's Flash Update
- Premier June 2016 MACRA comments

CMS Resources

- Final rule
- CMS QPP Website CMS press release
- CMS blog post by Andy Slavitt
- ONC fact sheet: QPP and Health IT

MACRA Blue Print

MACRA Challenges

- Based on 30 MACRA assessments, organizations are finding it to be more complex that previously
- A logical roadmap exists to prepare and maximize your MACRA opportunities and success
- Setting an appropriate direction is complex/challenging
  - *57% of organizations change the preliminary strategic direction after an assessment – with 75% deciding to take less risk than originally thought*
- The impact on hospitals and providers is significant however success can be attained in the MACRA journey
  - *It's estimated 592,000 and 642,000 clinicians are expected to submit data for MIPS and that more than 125,000 clinicians will participate in advanced* APMs for the 2018 performance year

MACRA Challenge and Product Blue Print

	MACRA Strategy	MACRA Implementation	Value Based Payment Alignment	Value Based Payment Optimization
Challenges	**Understanding the implications and developing a roadmap**	**Ensuring success under MIPS, APMs and AAPMs and preparing for future payment strategies**	**Measuring and aligning physician performance with compensation and payment models**	**Improving physician, APM, and AAPM performance in new, evolving payment framework**
Outcomes	Knowledge, strategy and roadmap for MACRA tied to overall Population Health journey	Effective management of transition	Systems and structures, including compensation and reporting, aligned to new framework	Thriving and winning in the move from volume to value

Education and Exploration

- Executives/Physician Leaders/Department Chairs/CIN participants

Assessment and Strategic & Operational Roadmap Development

- TINs, current MIPS performance, Physician compensation alignment, ITS solutions, etc.,

MIPS Reporting

- MIPS self reporting, MIPS reporting program

Alternative Payment Strategies

- **MSSP, NextGen, BP, Inflow Health, CIN, physician compensation alignment, etc.**

Benchmarking and Performance Improvement

- MIPS Continuous performance improvement
- APM performance improvement
- AAPM performance improvement

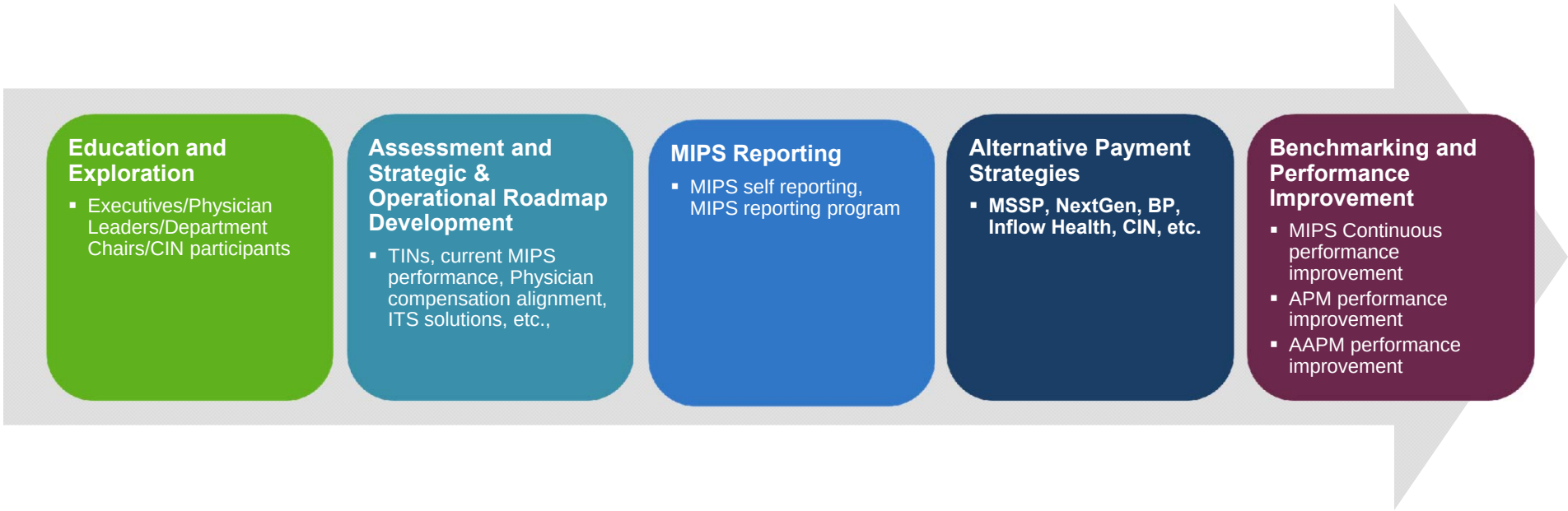
Transforming Healthcare TOGETHER

Appendix

MSSP Track 1 System Owned East Coast ACO

- Health System with an MSSP (Track 1) which earned millions of dollars in Shared Savings in first two years
- The preliminary MACRA plan was to become an Advanced APM model
- MACRA assessment finding
  - MSSP was foregoing $1 Million in additional shared savings by not being in a two sided risk model (AAPM)
  - The organization would meet the 25% minimum for AAPM payments and would receive a $1 Million MACRA bonus (5%)
  - The organization would be at risk to repay CMS up to $13 Million in a two sided risk model due to excessive utilization rates
  - The employed physicians are paid on an RVU basis (misalignment with MSSP) and therefore creating significant downside risk
- The organization decided to remain in Track 1 while revising the physician compensation program and enhancing key capabilities

Stages in the MACRA Journey (Where are You?)



Education and Exploration

- **MACRA Challenge**
  a. What is the law?
  b. What does it mean for my organization?
  c. How will our clinicians be impacted?
  d. How can we align?

- **MACRA Educational and Exploration Solution**
  a. Customized MACRA education tailored for specific audiences such as the Board, Senior Leadership, Physicians and Other Clinicians
  b. Advisory Services concerning a specific approach to determining the organization's MACRA Road Map
  c. Collaborative offerings to match which track an organization may choose (Population Health Management, QUEST, Bundled Payment)

Assessment and Strategic / Operational Roadmap

- **MACRA Challenge**
  a. Determine an appropriate strategic direction (MIPS, APM, and AAPM)
  b. What the financial implications, risks, opportunities, and options
  c. Assess how physicians are currently performing

- **MACRA Assessment and Strategic/Operational Roadmap Solution**
  a. Onsite education to understand alternatives, opportunities and challenges
  b. Assessing options of the financial implication of MIPS, APM, and AAPM
  c. Workshop to analyze and determine the optimal strategic direction
  d. Deep dive into one operational challenge (e.g. MIPS quality performance, developing a MSSP, etc.)

MIPS Reporting

- **MACRA Challenge**
  a. Numerous regulatory requirements
  b. Burdensome data collection from multiple sources
  c. Consolidation of measures into a consolidated report

- **MIPS Reporting Solution**
  a. Cross continuum access for hospital and providers to manage regulatory requirements
  b. Streamlines reporting and reduces data collection burden
  c. Measures and tracks performance for network, service line, and individual clinicians on one platform

Alternative Payment Model Strategies

- **MACRA Challenge**
  a. Selecting appropriate APM/AAPM for an organization based on financial expectations and appetite for risk
  b. Developing a model which aligns incentives

- **MACRA APM/AAPM Strategies Solutions**
  a. One-to-one advisory services including:
     a. Financial analysis/Risk assessment on APM/AAPM models
     b. Development of a clinically integrated network (CIN)
     c. Development of PCMH development, Care Management, etc.
  b. Collaborative's which provide benchmarking and Performance improvement assistance

Advanced Alternative Payment Models

- **The qualifying programs for 2017 are:**
  a. Comprehensive ESRD Care (CEC) Model – (Large Dialysis Organizations (LDO) arrangements and non-LDO two-sided risk arrangement)
  b. Comprehensive Primary Care Plus Initiative Model
  c. Medicare Shared Savings Program Tracks 2 and 3
  d. Next Generation ACO model
  e. Oncology Care Model (two-sided risk arrangement)
  f. Vermont Medicare ACO Initiative (as part of the Vermont All-payer ACO model)

- **CMS is developing new models for 2018 which may qualify as an Advanced APM depending on final rules**
  a. Advancing Care Coordination through Episode Payment Models (EPMs) Track 1 (CEHRT)
  b. Advancing Care Coordination through Episode Payment Models (EPMs) Track 2 (non-CEHRT)
  c. Cardiac Rehabilitation (CR) Incentive Payment Model
  d. Comprehensive Care for Joint Replacement (CJR) Payment Model (CEHRT)
  e. Medicare ACO Track 1+
  f. Medicare Diabetes Prevention Program (MDPP) Model

Performance Improvement

- **MACRA Challenge**
  a. Prioritizing the improvement opportunities in cost, quality and care coordination
  b. Identifying best practices
  c. Achieving results on these improvement opportunities

- **Performance Improvement for MIPS, APMs, and AAPMs Solutions**
  a. PI services will provide customized PI project support within the agreed-upon initiatives identified via a prioritized work plan
  b. Benchmarking for APM/AAPMs and educational resources to support improvement initiatives
  c. On-site assessments to identify practice variation
  d. Data analytics to identify variations in the practice setting
  e. Executive review of opportunities based on findings
  f. Improvement maps to guide specific interventions

MACRA Subject Matter Expertise

- Premier has conducted over 30 MACRA related engagements nationally
- The Premier team has over 70 population health experts, 20 of which have MACRA specific expertise
- Premier has been ranked by best in KLAS in value based care (population health management) consulting in country

MSSP Track 1 Physician Owned Southeastern ACO

- 2013: Newly formed ACO engaged 52 PCPs, and accepted to MSSP without care management in place
- 2014 April – November:
  - Premier on site weekly to create vision, plan and infrastructure for system-wide care management program:
    - » Training program with expedited approach to health crisis intervention for Emergency Room avoidance implemented July
    - » Complex care program & telephonic program for rising risk deterrence initiated August 2014
    - » PCMH capabilities with culture and workflow redesign in practices across the system
  - Executed plan for ongoing physician engagement
- 2014: No MSSP savings generated
- 2015: First year with care management program, ACO generated savings in excess of $11M and subsequently able to expand to include 70 PCPs (35% growth)

MIPS: Quality Performance Scoring Example

Measure	Measure Type	Points Based on Performance	Total Possible Points	Quality Bonus Points for High Priority	Quality Bonus Points for CEHRT
1	Outcome Measure using CEHRT	4.1	10	0 (required)	1
2	Outcome Measure using CEHRT	9.3	10	2	1
3	Patient Experience using CEHRT	10	10	2	1
4	High Priority using CEHRT	10	10	1	1
5	Outcome Measure using CEHRT	9	10	2	1
6	Outcome Measure using CEHRT	8.4	10	2	1
Total:		50.8	60	9	6
Cap applied to Bonus Categories (10%x total possible points):				6	6
Total with High Priority CEHRT Bonus:		60			

MIPS Final Rule Estimated Impact on Total Allowed Charges by Specialty, Standard Participation Assumptions

Provider Type	Number of Physicians and Other Clinicians	Allowed Charges (mil)	Percent with Positive or Neutral Payment Adjustment	Percent with Negative Payment Adjustment	Aggregate Impact Positive Payment Adjustment (mil)	Aggregate Impact Negative Adjustment (mil)
All	676,722	$78,454	94.7%	5.3%	$699	-$199
Allergy/Immunology	2,389	$251	92.1%	7.9%	$2	-$1
Anesthesiology	29,845	$1,982	95.7%	4.3%	$11	-$5
Cardiology	24,657	$5,172	95.0%	5.0%	$54	-$11
Chiropractic	4,485	$247	87.8%	12.2%	$1	-$1
Clinical Nurse Specialists	1,267	$46	91.0%	9.0%	$0	$0
Colon/Rectal Surgery	1,170	$125	96.3%	3.7%	$1	$0
Critical Care	2,560	$257	93.8%	6.2%	$2	-$1
Dentist	447	$16	94.2%	5.8%	$0	$0
Dermatology	10,328	$2,960	92.1%	7.9%	$24	-$8
Emergency Medicine	41,687	$2,722	97.3%	2.7%	$13	-$3
Endocrinology	5,065	$474	96.4%	3.6%	$5	-$1
Family Medicine	71,073	$5,802	95.0%	5.0%	$62	-$15
Gastroenterology	12,168	$1,595	95.6%	4.4%	$16	-$3
General Practice	2,389	$228	90.0%	10.0%	$2	-$1
General Surgery	18,118	$1,734	94.5%	5.5%	$17	-$5
Geriatrics	3,044	$371	94.0%	6.0%	$4	-$1

MIPS Final Rule Estimated Impact on Total Allowed Charges by Specialty, Standard Participation Assumptions

Provider Type	Number of Physicians and Other Clinicians	Allowed Charges (mil)	Percent with Positive or Neutral Payment Adjustment	Percent with Negative Payment Adjustment	Aggregate Impact Positive Payment Adjustment (mil)	Aggregate Impact Negative Adjustment (mil)
Hand Surgery	1,769	$253	91.2%	8.8%	$2	-$1
Infectious Diseases	5,412	$684	94.1%	5.9%	$6	-$2
Internal Medicine	80,871	$9,320	94.3%	5.7%	$95	-$25
Interventional Radiology	1,886	$389	96.7%	3.3%	$2	-$1
Nephrology	7,048	$1,598	94.3%	5.7%	$15	-$4
Neurology	12,540	$1,405	94.4%	5.6%	$13	-$5
Neurosurgery	4,470	$696	93.8%	6.2%	$6	-$2
Nuclear Medicine	540	$98	95.0%	5.0%	$1	$0
Nurse Anesthetist	23,892	$700	96.3%	3.7%	$4	-$2
Nurse Practitioner	51,004	$1,763	95.4%	4.6%	$16	-$8
Obstetrics/Gynecology	18,578	$487	97.3%	2.7%	$5	-$1
Oncology/Hematology	10,368	$4,747	95.3%	4.7%	$40	-$10
Ophthalmology	16,502	$7,689	96.3%	3.7%	$89	-$5
Optometry	12,116	$926	93.3%	6.7%	$7	-$2
Oral/Maxillofacial Surgery	129	$5	96.1%	3.9%	$0	$0

MIPS Final Rule Estimated Impact on Total Allowed Charges by Specialty, Standard Participation Assumptions

Provider Type	Number of Physicians and Other Clinicians	Allowed Charges (mil)	Percent with Positive or Neutral Payment Adjustment	Percent with Negative Payment Adjustment	Aggregate Impact Positive Payment Adjustment (mil)	Aggregate Impact Negative Adjustment (mil)
Orthopedic Surgery	19,360	$3,286	92.0%	8.0%	$26	-$11
Other MD/DO	10,764	$1,281	93.3%	6.7%	$11	-$5
Otolaryngology	7,812	$969	93.4%	6.6%	$8	-$3
Pathology	10,433	$1,020	96.0%	4.0%	$6	-$4
Pediatrics	4,565	$59	99.0%	1.0%	$1	$0
Physical Medicine	6,357	$997	90.9%	9.1%	$7	-$4
Physician Assistant	42,402	$1,284	96.2%	3.8%	$11	-$4
Plastic Surgery	2,449	$243	93.9%	6.1%	$2	-$1
Podiatry	13,598	$1,800	87.7%	12.3%	$12	-$9
Psychiatry	14,044	$864	86.2%	13.8%	$6	-$8
Pulmonary Disease	9,910	$1,535	94.3%	5.7%	$15	-$4
Radiation Oncology	3,364	$1,160	95.1%	4.9%	$10	-$3
Radiology	34,613	$4,507	95.3%	4.7%	$27	-$10
Rheumatology	3,865	$1,353	96.4%	3.6%	$13	-$2
Thoracic/Cardiac Surgery	3,333	$559	97.5%	2.5%	$6	-$1
Urology	8,956	$1,924	95.1%	4.9%	$16	-$4
Vascular Surgery	3,080	$871	94.5%	5.5%	$7	-$2

MIPS Final Rule Estimated Impact on Total Allowed Charges by Specialty, Alternative Participation Assumptions

Provider Type	Number of Physicians and Other Clinicians	Allowed Charges (mil)	Percent with Positive or Neutral Payment Adjustment	Percent with Negative Payment Adjustment	Aggregate Impact Positive Payment Adjustment (mil)	Aggregate Impact Negative Adjustment (mil)
All	676,722	$78,454	91.9%	8.1%	$821	-$321
Allergy/Immunology	2,389	$251	85.1%	14.9%	$2	-$2
Anesthesiology	29,845	$1,982	94.2%	5.8%	$13	-$8
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