Who Participates in AMGA?

Approximately 440 Medical Groups with more than 175,000 physicians, including:

- Sutter Health
- Mayo Clinic Health System
- Kaiser Permanente
- Cleveland Clinic
- Partners Healthcare
- Catholic Health Initiatives
- Dartmouth-Hitchcock
- HealthPartners
- Mercy
- Prevea Health
- Intermountain Healthcare
- Trinity Health
- Geisinger
- Advocate Medical Group
- PeaceHealth
- Crystal Run Healthcare
Presentation Outline

MACRA Basics

Merit-Based Incentive Payment System (MIPS)
- Eligible Clinicians (ECs) and Exemptions
- MIPS Reporting and Performance Categories

Advanced Alternative Payment Models (APMs)
- 2017 Performance Year Models
- Patient and Payment Thresholds

Looking Toward 2018
- Medical Group preparations

Medicare Part B Payments

Part B Payment = Work RVU x Work GPCI + PE RVU x PE GPCI + MP RVU x MP GPCI

MACRA adjusts the Part B Payment
### MIPS: Who’s In

**Years 1 – 2 (2017-2018)**
- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists

**Potential additions (2019+)**
- Physical or Occupational Therapists
- Speech Language Pathologists
- Audiologists
- Nurse Midwives
- Clinical Social Workers
- Clinical Pathologists
- Clinical Psychologists
- Dietitians/Nutritional Professionals

### MIPS: Who’s Out

- Providers below the Medicare low-volume threshold
  - $30,000 OR 100 or fewer beneficiaries annually
- First year Medicare providers
- Providers in an Advanced Alternative Payment Model
MIPS: Four Components

- Quality: 60% (60-70 Points)
- Advancing Care Information: 25% (100+ Points)
- Improvement Activities: 15% (40 Points)
- Cost: 0%

Add each weighted category to earn MIPS Composite Performance Score

Quality + Advancing Care Information + Improvement Activities + Cost = MIPS Score

MIPS Payments

2018: -4%
2019: +4*
2020: -5%
2021: +7*
2022: +9*
2023+: +9*
MIPS: “Pick Your Pace” Payment Adjustment

2017 performance determines 2019 payment adjustment

1. Submit no data = -4% update
2. One quality measure OR one improvement activity OR the required advancing care information measures: neutral or positive MIPS update
   1) If reporting via GPRO must meet case minimum requirements
3. More than one quality measure, OR more than one improvement activity, OR advancing care information base measures: positive update possible, avoid negative update

(Medicare physician fee schedule updated 0.5% from 2015-2019)

MIPS: Quality Measures Reporting Full Participation

Groups of 25+:
GPRO on first
248 beneficiaries

Proposed Cross-
Cutting Measure not
finalized

Reporting
Periods and
Benchmarks Vary

6 quality measures or
specialty/sub-specialty measure set

1 Outcome Measure or
“High Priority” if outcome unavailable

All Cause Hospital Admission (ACHA) for Groups of 16 or more
Selecting Quality Measures

Quality Payment Program

Quality Measures

Instructions
1. Review and select measures that best fit your practice.
2. Add up to six measures from the list below. Including one outcome measure. You can use the search and filters to help find the measures that meet your needs or specialty.
3. If an outcome measure is not available that is applicable to your specialty or practice, choose another high priority measure.
4. Download a CSV file of the measures you have selected for your records.

Groups in APMs qualifying for special scoring standards under MIPS, such as Shared Savings Program Track 1 or the Oncology Care Model, report quality measures through your APM. You do not need to do anything additional for the MIPS quality category.

Note: This tool is for informational and estimation purposes. You can't use it to submit or attest to measures or activities.

https://qpp.cms.gov/measures/quality

Immunization Quality Measures

Childhood Immunization Status
- Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday

Preventive Care and Screening: Influenza Immunization
- Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization
MIPS: Improvement Activities Reporting

- Attest completion of minimum of 4 activities for 90 days
- Rural or Small Practice: Attest 2 activities for 90 days
- Full Credit for PCMH
- Half Credit for other APMs
- 15% Weight (2017)

Expanded Care Access
Care Coordination
Population Management
Beneficiary Engagement
Patient Safety and Practice Assessment
Achieving Health Equity
Emergency Preparedness and Response
Integrated Behavior and Mental Health

Selecting Improvement Activities

Improvement Activities

Instructions

1. Review and select activities that best fit your practice.
   - Most participants: Attest that you completed up to 4 improvement activities for a minimum of 90 days.
   - Groups with fewer than 15 participants or if you are in a rural or health professional shortage area: Attest that you completed up to 2 activities for a minimum of 90 days.
   - Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model: You will automatically earn full credit.
   - Participants in certain APMs under the APM scoring standard, such as Shared Savings Program Track 1 or OCM: You will automatically be scored based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.
   - Participants in any other APM: You will automatically earn half credit and may report additional activities to increase your score.

2. Download a CSV file of the activities you have selected for your records.

https://qpp.cms.gov/measures/ia
MIPS: Advancing Care Information Reporting

- Has base and performance reporting components
- Final rule reduced required “base” measures from 11 to 5
- 9 performance measures
- 2015 CEHRT required to report in the ACI category in 2018
- 90-day performance period (reduction from full year)

Selecting ACI Measures

Advancing Care Information

In 2017, there are two measure set options for reporting. The option you use to submit your data is based on your electronic health record edition.

- **Option 1:** Advancing Care Information Objectives and Measures
- **Option 2:** 2017 Advancing Care Information Transition Objectives and Measures

You can report the Advancing Care Information Objectives and Measures:

- If you have technology certified to the 2015 Edition; or
- If you have a combination of technologies from 2014 and 2015 Editions that support these measures.

You can report the 2017 Advancing Care Information Transition Objectives and Measures:

- If you have technology certified to the 2015 Edition; or
- If you have technology certified to the 2014 Edition; or
- If you have a combination of technologies from 2014 and 2015 Editions.

https://qpp.cms.gov/measures/aci
MIPS: Cost

0% in 2017
10% in 2018
30% in 2019

CMS will consider how to include Part D into the cost category
Rejected requests to remove Part B drugs

MIPS: Data Submission
Benchmarks Differ by Method

<table>
<thead>
<tr>
<th>Individual Clinician</th>
<th>Group (One TIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Quality</td>
</tr>
<tr>
<td>• Qualified Clinical Data Registry (QCDR)</td>
<td>• QCDR</td>
</tr>
<tr>
<td>• Qualified Registry</td>
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</tr>
<tr>
<td>• EHR Vendors</td>
<td>• EHR Vendor</td>
</tr>
<tr>
<td>• Claims (No submission needed)</td>
<td>• CMS Web Interface (GPRO)</td>
</tr>
<tr>
<td>• Resource Use</td>
<td>• CAHPS</td>
</tr>
<tr>
<td>• Claims (No submission needed)</td>
<td>• Resource Use</td>
</tr>
<tr>
<td>• Advanced Care Information</td>
<td>• Claims (No submission needed)</td>
</tr>
<tr>
<td>• Attestation</td>
<td>• Advanced Care Information</td>
</tr>
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<td>• Clinical Practice Improvement Activities</td>
<td>• CMS Web Interface (Group of 25+)</td>
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<td>• Claims (No submission needed)</td>
<td>• Clinical Practice Improvement</td>
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2017 National Adult and Influenza Immunization Summit - 5/9/2017
MIPS: Exceptional Performance Bonus

- $500 million available each year from 2019 – 2024 for those with exceptional performance
- Exceptional performance threshold is 70 points for performance year 2017
- Limited to stop-gain restrictions

Exceptional threshold: 70 points
A share of $500 million

Alternative Payment Models (APMs)

MIPS APMs (No 5% Bonus)
Partially-Qualifying APMs (No 5% Bonus & MIPS Choice)
Advanced APMs (5% Bonus)
What are MIPS APMs?

Goals
- Reduce eligible clinician reporting burden.
- Maintain focus on the goals and objectives of APMs.

How does it work?
- Streamlined MIPS reporting and scoring for eligible clinicians in certain APMs.
- Aggregates eligible clinician MIPS scores to the APM Entity level.
- All eligible clinicians in an APM Entity receive the same MIPS final score.
- Uses APM-related performance to the extent practicable.

Shared Savings Program under the APM Scoring Standard

<table>
<thead>
<tr>
<th>REPORTING REQUIREMENT</th>
<th>PERFORMANCE SCORE</th>
<th>WEIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ No additional reporting necessary. ACOs submit quality measures to the CMS Web Interface on behalf of their participating MIPS eligible clinicians.</td>
<td>The MIPS quality performance category requirements and benchmarks will be used to score quality at the ACO level.</td>
<td>50%</td>
</tr>
<tr>
<td>✓ MIPS eligible clinicians will not be assessed on cost.</td>
<td>N/A</td>
<td>0%</td>
</tr>
<tr>
<td>✓ No additional reporting necessary.</td>
<td>CMS will assign a 100% score to each APM Entity group based on the activities required of participants in the Shared Savings Program.</td>
<td>20%</td>
</tr>
<tr>
<td>✓ Each ACO participant TIN in the ACO submits under this category according to MIPS reporting requirements.</td>
<td>All of the ACO participant TIN scores will be aggregated as a weighted average based on the number of MIPS eligible clinicians in each TIN to yield one APM Entity group score.</td>
<td>30%</td>
</tr>
</tbody>
</table>
Advanced APM Requirements

- Be a CMS Innovation Center model
- Use Certified EHR Technology (CEHRT)
  - For 2017 50% of QPs would need to use CEHRT
- Base payments for services on quality measures comparable to those in MIPS
- Be a Medical Home expanded under Medicare Innovation Center OR require participants to “bear more than nominal financial risk for losses”
- ECs will be notified of their APM status before the end of the performance year
- CMS will take three “snapshots” during the performance period: March 31, June 30, and August 31 to identify qualifying participants (QPs) – not only at December 31 as proposed

Advanced APM Thresholds (2019+)

**Qualifying Payment Threshold**
- 2019-2020: 25%
- 2021-2022: 50%
- 2023+: 75%

**Qualifying Beneficiary Threshold**
- 2019-2020: 20%
- 2021-2022: 35%
- 2023+: 50%

**Quality Measures and CEHRT**
- Measures similar to MIPS
- Certified Electronic Health Records Technology

Beneficiaries defined as "eligible" not "assigned"

Payment and patient determinations are determined from January 1 – August 1 of the performance year

Medicare only option for 2017 and 2018

See table 32 in final rule
Partially Qualifying Medicare Thresholds

**Partially-Qualifying Payment Threshold**
- 2019-2020: 10%
- 2021-2022: 25%
- 2023+: 50%

Do not meet revenue or patient thresholds for Advanced APMs
CMS lowered partially-qualifying payment threshold
Can choose whether to report under MIPS
Those who report subject to all MIPS requirements and would receive a MIPS payment adjustment
Does not qualify for 5% Advanced APM bonus

**Partially-Qualifying Beneficiary Threshold**
- 2019-2020: 10%
- 2021-2022: 25%
- 2023+: 35%

Advanced APMs: Bonus Payment

- 5% of aggregate amounts paid for Medicare Part B professional services from preceding year across all billing TINS associated with the QPs NPI
- CMS estimates $333 million to $571 million in Advanced APM bonus payments in 2019
CMS “Pre-Approved” Advanced APMs

2017 Performance Year

- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Shared Savings Program - Track 2
- Shared Savings Program - Track 3
- Oncology Care Model (OCM) - Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

Updated on an ad hoc basis – will not go through formal rulemaking process

2018 Performance Year and beyond

- ACO Track 1+
- Episode (bundled) payment models to be determined

Medical Group Response

- Strong incentives to address the overall cost of care
- Strong incentives to form APMs
- Improve Quality and Outcomes
  - Device or Drug must be statistically significantly better than the competition
- Systems and groups will look for one solution
  - Physician preference not a factor anymore
- Reduce pharmacy spend
  - Drugs among most costly items
  - Practice formulary
  - Monitor adherence and tie to physician compensation
Thank You

Questions/Comments

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