



**MACRA and  
Provider Group Perspectives**

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AMGA**

**2017 National Adult and Influenza  
Immunization Summit**

### Who Participates in AMGA?



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























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# Presentation Outline



## MACRA Basics

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

- Eligible Clinicians (ECs) and Exemptions
- MIPS Reporting and Performance Categories

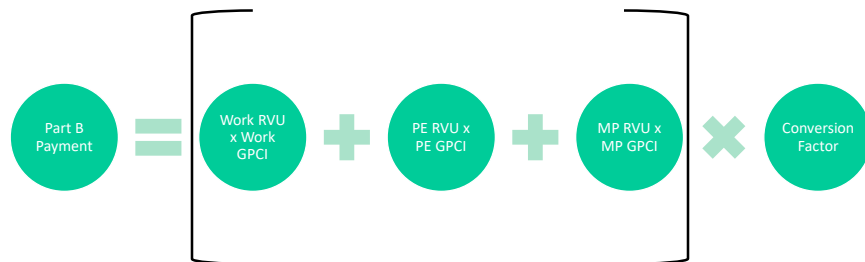
### Advanced Alternative Payment Models (APMs)

- 2017 Performance Year Models
- Patient and Payment Thresholds

### Looking Toward 2018

- Medical Group preparations

# Medicare Part B Payments



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

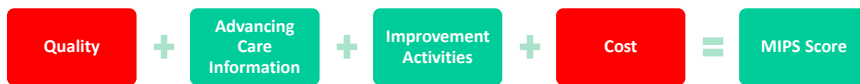


- Providers below the Medicare low-volume threshold
  - \$30,000 **OR** 100 or fewer beneficiaries annually
- First year Medicare providers
- Providers in an Advanced Alternative Payment Model

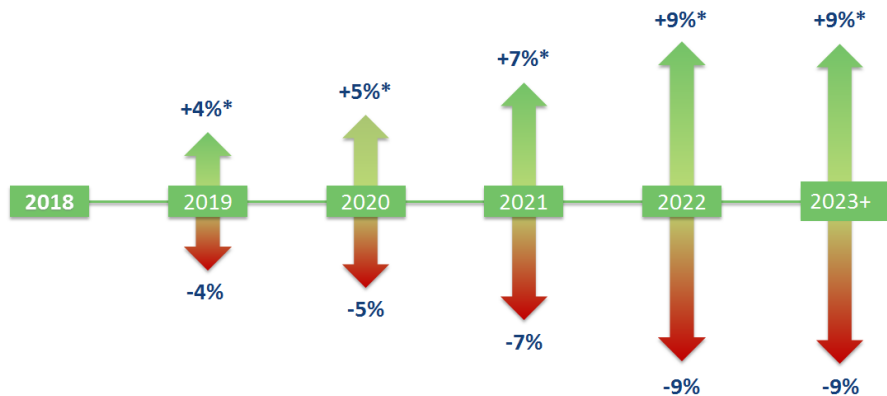
## MIPS: Four Components



Add each weighted category to earn MIPS Composite Performance Score



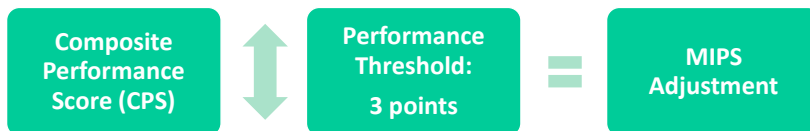
## MIPS Payments



## MIPS: “Pick Your Pace” Payment Adjustment



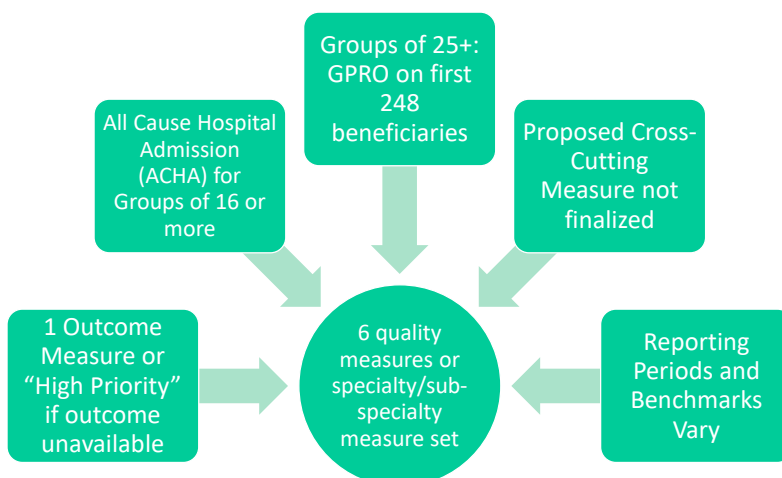
2017 performance determines 2019 payment adjustment



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



# Selecting Quality Measures



Quality Payment Program

Learn About the Program | Explore Measures | Education & Tools

Program Performance | **Quality Measures** | Advancing Care Information | Improvement Activities

## Quality Measures

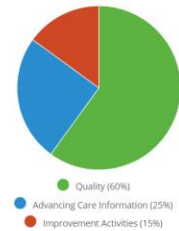
### Instructions

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 only for informational and estimation purposes. You can't use it to submit or attest to measures or activities.

### 2017 MIPS Performance



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

# Immunization Quality Measures



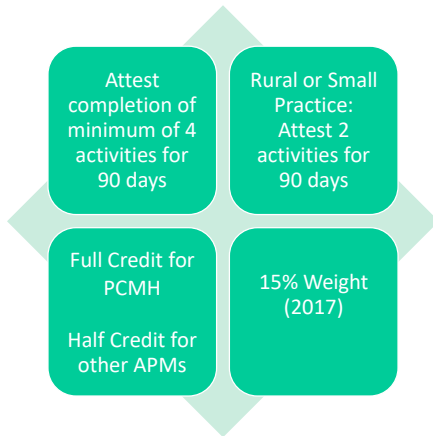
## Childhood Immunization Status

- 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



- 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



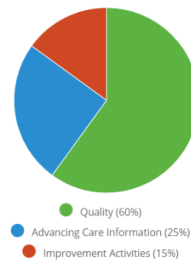
## Improvement Activities

In this new performance category for 2017, clinicians are rewarded for care focused on care coordination, beneficiary engagement, and patient safety.

### Instructions

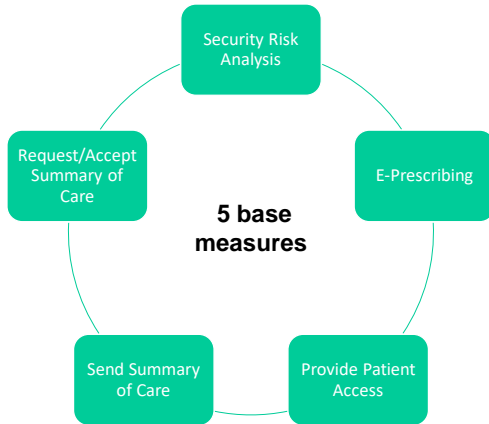
1. Review and select activities that best fit your practice.
  - o **Most participants:** Attest that you completed up to 4 Improvement activities for a minimum of 90 days.
  - o **Groups with fewer than 15 participants or if you are in a rural or health professional shortage area:** Attest that you completed up to 2 activities for a minimum of 90 days.
  - o **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.
  - o **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.
  - o **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.

### 2017 MIPS Performance



<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

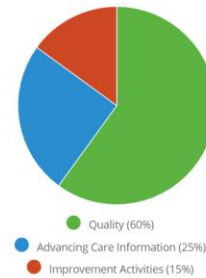
You can report the Advancing Care Information Objectives and Measures:

- 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:

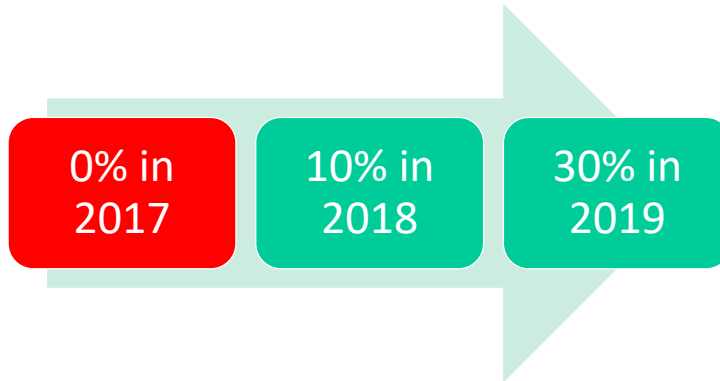
- If you have technology certified to the 2015 Edition; or
- If you have technology certified to the 2014 Edition; or
- If you have a combination of technologies from 2014 and 2015 Editions.

### 2017 MIPS Performance



<https://qpp.cms.gov/measures/aci>

## MIPS: Cost



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



Individual Clinician	Group (One TIN)
<ul style="list-style-type: none"> <li>• <b>Quality</b> <ul style="list-style-type: none"> <li>• Qualified Clinical Data Registry (QCDR)</li> <li>• Qualified Registry</li> <li>• EHR Vendors</li> <li>• Claims (No submission needed)</li> </ul> </li> <li>• <b>Resource Use</b> <ul style="list-style-type: none"> <li>• Claims (No submission needed)</li> </ul> </li> <li>• <b>Advanced Care Information</b> <ul style="list-style-type: none"> <li>• Attestation</li> <li>• QCDR</li> <li>• Qualified Registry</li> <li>• EHR Vendor</li> </ul> </li> <li>• <b>Clinical Practice Improvement Activities</b> <ul style="list-style-type: none"> <li>• Attestation</li> <li>• QCDR</li> <li>• EHR Vendor</li> <li>• Claims (No submission needed)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>Quality</b> <ul style="list-style-type: none"> <li>• QCDR</li> <li>• Qualified Registry</li> <li>• EHR Vendors</li> <li>• CMS Web Interface (GPRO)</li> <li>• CAHPS</li> </ul> </li> <li>• <b>Resource Use</b> <ul style="list-style-type: none"> <li>• Claims (No submission needed)</li> </ul> </li> <li>• <b>Advanced Care Information</b> <ul style="list-style-type: none"> <li>• Attestation</li> <li>• QCDR</li> <li>• Qualified Registry</li> <li>• EHR Vendor</li> <li>• CMS Web Interface (Group of 25+) (GPRO)</li> </ul> </li> <li>• <b>Clinical Practice Improvement Activities</b> <ul style="list-style-type: none"> <li>• Attestation</li> <li>• QCDR</li> <li>• Qualified Registry</li> <li>• EHR Vendor</li> <li>• CMS Web Interface (Group of 25+) (GPRO)</li> </ul> </li> </ul>

## 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



## 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?



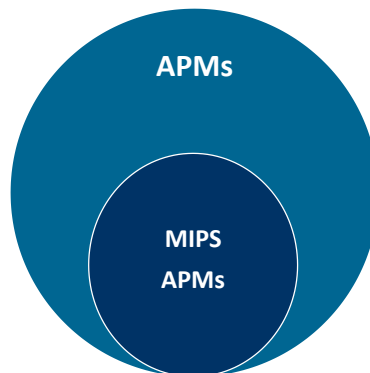
### Goals

- 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.

MIPS APMs are a Subset of APMs



## Shared Savings Program under the APM Scoring Standard



Quality



Cost



Improvement Activities



Advancing Care

	REPORTING REQUIREMENT	PERFORMANCE SCORE	WEIGHT
Quality	✓ No additional reporting necessary. ACOs submit quality measures to the CMS Web Interface on behalf of their participating MIPS eligible clinicians.	✓ The MIPS quality performance category requirements and benchmarks will be used to score quality at the ACO level.	50%
Cost	✓ MIPS eligible clinicians will not be assessed on cost.	✓ N/A	0%
Improvement Activities	✓ No additional reporting necessary.	✓ CMS will assign a 100% score to each APM Entity group based on the activities required of participants in the Shared Savings Program.	20%
Advancing Care	✓ Each ACO participant TIN in the ACO submits under this category according to MIPS reporting requirements.	✓ 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.	30%



## 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

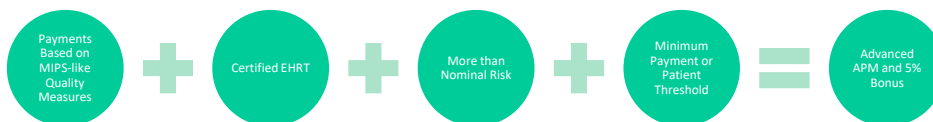
Those who report subject to all MIPS requirements and would receive a MIPS payment adjustment

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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