HIMSS NORTH CAROLINA Chapter

The Quality Payment Program 2017 Final Regulations

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

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Panel Agenda

- What is MACRA?
- Who is Impacted?
- What are the Top 3 Considerations?
- What are the Paths?
- Best recommendations for succeeding in MACRA
  - Planning
  - Measure selection
  - Mechanism selection
  - Consolidation
- Questions
  - Where do I start?

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The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

What is MACRA?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is bipartisan federal legislation signed into law on April 16, 2015. The law does many things, but most importantly it establishes new ways to pay physicians for caring for Medicare beneficiaries

- Repeals the Sustainable Growth Rate (SGR) Formula
- Introduces The Quality Payment Program (QPP)
  - The Merit-based Incentive Payment System (MIPS)
  - Advanced Alternate Payment Models (APM)
- The QPP impacts Providers who bill Medicare Part B
- Majority of Eligible Clinicians (EC) should prepare for MIPS but plan for future APM as a Qualifying Participant (QP)
  - The QPP drives healthcare from volume to value based reimbursement

Who is Impacted?

- Eligible Clinician's who bill Medicare Part B
- MIPS-eligible clinician defined as:
  - Physician
  - Physician Assistant
  - Nurse Practitioner
  - Clinical nurse specialist
  - Certified registered nurse anesthetist
- Exemptions include:
  - Newly Eligible Clinicians
  - Less than 30K of Medicare Part B per year
  - Less than 100 Medicare Patients per year

- This is a larger subset than the previous Eligible Professional Definition under Meaningful Use.
- MIPS can be reported as a Group or as an Individual.

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What are the top 3 Considerations?

#1 - Impact	#2 - Path	#3 - Timeline
Eligible Clinicians who bill Medicare Part B • Physicians, PA, NP, CNS, CRNA  Exemptions: • Newly Eligible Clinicians • <30K of Medicare Part B per year • <100 Medicare Patients per year	Advanced Alternative Payment Models (APM) • Thresholds required • ECs may not be QPs, but could qualify for exemption or MIPS flexibility The Merit-based Incentive Payment System (MIPS) • 2017 Transition Year • Submit minimal data to avoid Penalty • No Cost Category • Incentives for High Performers 	January 1, 2017 • APM Participation • Full Year for MIPS (Not Required)  October 2, 2017 • Last day to begin 90 day MIPS reporting 4 Options to 2017 • APM (QP) • Submit minimal data • Submit data for 90 days • Submit data for >90 days Negative Adjustment only for ECs who do not submit any data in 2017

Two Paths of the Quality Payment Program

2017 Eligible APMs:

- **Comprehensive ESRD Care Model**
- **CPC+**
- **MSSP Track 2 or Track 3**
- **Next Generation ACO Model**
- **Oncology Care Model (2-Sided Risk)**

APM Qualifying Participant:
>= 25% of Medicare Payments
OR >= 20% Medicare Patients

An EC in APM could fall below the QP thresholds, but could still exempt from MIPS

Submit as Group Or Individual
Composite Performance Score
Based on combination of following categories
Quality (60%)

- **PQRS**

Improvement Activities (15%)

- **PCMH**

Advancing Care Information (25%)

- **Meaningful Use**

Cost (0%)

- **Value-Based Payment Modifier**

% Change for future years

5% Increase for QPs in 2019

+/-4% Increase in 2019 for ECs in 2019
> Increase for Higher Performers

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Overview
Advanced Alternate Payment Models

CMS expects a majority of ECs to be on MIPS path, but the future goal is Value Based Reimbursement under the Advanced APM program.

OVERVIEW
• Qualifying Participants (QPs) in APMs not subject to MIPS • QPs eligible to earn 5% lump sum bonus payments for years 2019–2024 • Advanced APM List will be finalized prior to January 1, 2017
Advanced APM Requirements

• CMS Innovation Center models, Shared Savings Program tracks, or certain federal demonstration programs (Proposed on Previous Slides)
• Use of Certified EHR technology
• Base payments for services on quality measures
• Be a Medical Home Model expanded under Innovation Center authority or require participants to bear more than nominal financial risk for losses
  ○ Qualifying Participant in APM for 2017: >=25% of Medicare Payments OR >=20% Medicare Patients
  ○ Partial QP has >=20% Medicare Payment OR >=10% Medicare Patients will not qualify for 5% incentive, but exempt from MIPS

Overview and Eligibility of MIPS

OVERVIEW

- MIPS creates 4 Categories for consolidated Reporting: Cost, Quality, Clinical Practice Improvement Activities, and Advancing Care Information
  - Only 3 will be used in 2017 CPS (Cost included in 2018)
- 2017 is a Transition Year to ease ECs into the Program
  - No Penalty for submission of minimal data and no threshold requirement to avoid penalty (Majority – Single Quality Measure)
  - Increased Incentives available for higher performing data reported
- MIPS can be reported as a Group or as an Individual
- MIPS can be reported for continuous 90 days or longer in 2017
  - Reporting this 90-day period can differ across performance categories
- CPS Requirements transition thru the years

Required Composite Score Categories for 2017

With Requirements for Majority of Eligible Clinicians*

Quality (60%)
6 quality measures, including outcome measure

Improvement Activities (15%)
4 improvement activities for 90 days

Advancing Care Information (25%)
2017: 4 Required Measures plus Performance Measures
Security, e-Rx, Patient Access, HIE

Cost (0%)
Will be required in 2018

Overview and Eligibility of MIPS

Category	Quality	Improvement Activities	Resource Use	Advancing Care Information
Score	60%	15%	0%	25%
Requirements	Report 6 Quality Measures Including an outcome measure, for a minimum of 90 days	4 Improvement Activities for a minimum of 90 days Clinicians in PCHM get full credit.	Not Required for 2017 Plan for 2018 Cost measures calculated by CMS using claims.	Based on participation & performance on key technical capabilities (e.g., security, eRx, public health, patient access, patient engagement, HIE)
Learn From	PQRS	Patient Centered Medical Home	Value-based Modifier	Meaningful Use

Reporting Year CPS Requirements*	2017	*2017 APM*	2018	2019+
Quality (PQRS)	60%	*50%*	50%	30%
Cost (VM)	0%	*0%*	10%	30%
Improvement Activities (PCMH)	15%	*20%*	15%	15%
Advancing Care Information (MU)	25%	*30%*	25%	25%

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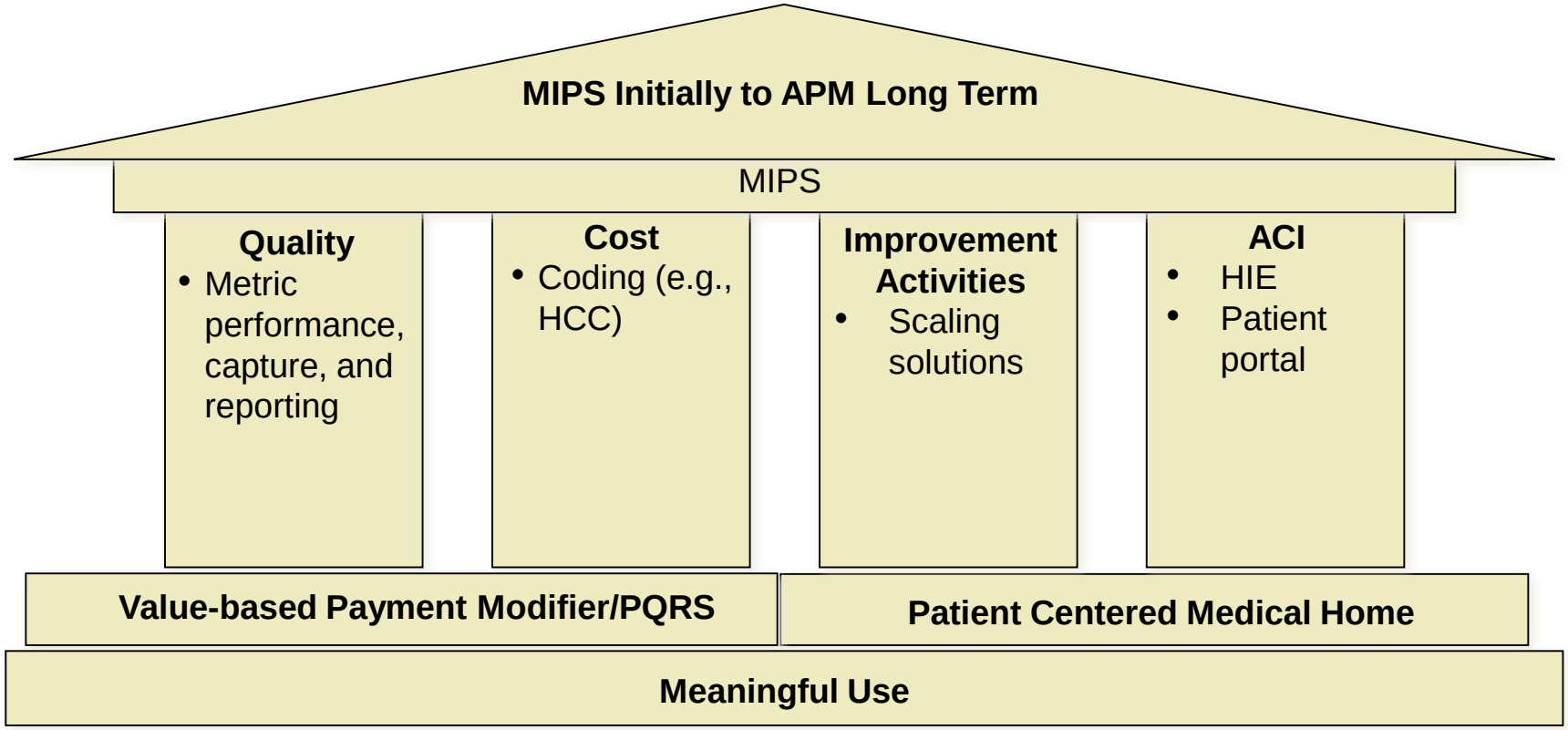
Recommendations for Success



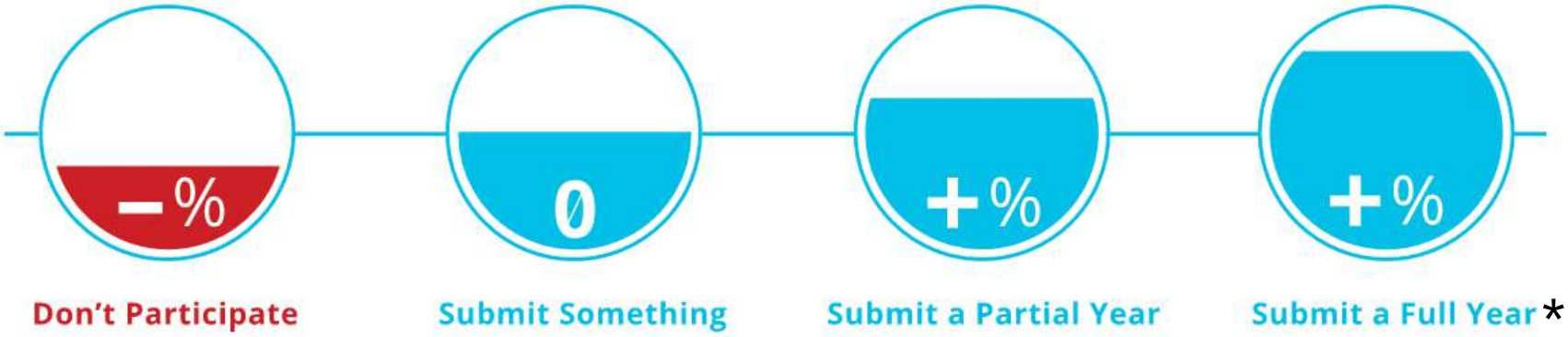
Key implications for IT

- Quality metrics should be starting point- metric planning begins now
- Patient portal & data sharing will be highest bars
- Claims data quality key- coding will be essential for meeting resource use targets
- EHR optimization will likely be needed- for PMCH care management processes
- Clear strategy for data submission- no credit for submission if data not submitted

MIPS: 2017 Pick your Pace

Pick Your Pace in MIPS

If you choose the MIPS path of the Quality Payment Program, you have three options.



Not participating in the Quality Payment Program:
If you don't send in any 2017 data, then you receive a negative 4% payment adjustment.

Test:
If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), you can avoid a downward payment adjustment.

Partial:
If you submit 90 days of 2017 data to Medicare, you may earn a neutral or positive payment adjustment.

Full:
If you submit a full year of 2017 data to Medicare, you may earn a positive payment adjustment.

**Positive adjustments are based on the performance data on the performance information submitted, not the amount of information or length of time submitted.*

Educational References

- Premier Advocacy and Regulatory Information*
  - https://www.premierinc.com/transforming-healthcare/healthcare-policy/
- MIPS: Improvement Activities tool
  - https://qpp.cms.gov/measures/ia

**Premier Inc. #1 2016 KLAS Rating for Healthcare Consulting/Value Based Care*

Acronyms

- MACRA – Medicare Access and CHIP Reauthorization Act of 2015
- QPP – Quality Payment Program
- APM – Alternative Payment Model
- MIPS – Merit-based incentive payment system
- CPC+ – Comprehensive Primary Care Plus
- EC – Eligible Clinicians for MACRA
- MSSP – Medicare Shared Saving Program
- PCMH – Patient-Centered Medical Home
- PQRS – Physician Quality Reporting System
- VBM – Value-Based Modifier
- MU – Meaningful Use
- SGR – Sustainable Growth Rate