SO, WHAT IS MACRA?

**MACRA** = The Medicare Access and CHIP Reauthorization Act

**Quality Payment Program (QPP)** = Meaningful Use + VBM + PQRS

Under QPP, two new payment tracks exist starting January 2017:

- Alternative Payment Models (APMs) and
- Merit-based Incentive Payment System (MIPS)
Overview: What are the main changes from Year 1 to Year 2?

**Year 1**
- >$30,000 in Medicare payments or >100 patients
- Quality is 60% of the final score
- Data completeness: 50%
- Cost was 0% of final score
- Performance Threshold 3 points
- Payment adjustment +/-4%
- Performance period min 90 days

**Year 2**
- >$90,000 in Medicare payments or >200 patients
- Quality is 50% of the final score
- Data completeness: 60%
- Virtual Groups available
- Cost is 10% of final score
- 5% bonus for small practices
- Performance Threshold 15 points
- Payment adjustment +/-5%
- Performance period min 12 months for Quality; all others 90 days
WHO WILL PARTICIPATE IN THE QPP?

You’re a part of the Quality Payment Program if you receive more than $90,000 a year from Medicare and provide care for more than 200 Medicare patients a year, and are a:

- Physician
- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetist
WHO DOES MIPS NOT AFFECT?

Only clinicians who meet one of the qualifiers below will be exempt from MIPS:

- Qualifying Advanced APMs;
- Low-volume provider (Has $90,000 or less Medicare-billing charges and provides Part B services to 200 or fewer Medicare beneficiaries in 2017);
- Newly enrolled in Medicare in 2018;
- Pediatric Medicaid provider.
WHAT HAPPENS IF I DON’T PARTICIPATE?

Providers that **do not participate** in the Quality Payment Program in 2018 will receive a negative (-) **5%** payment adjustment in 2020.
CATEGORIES OF MIPS

Quality: 50%
Improvement Activities: 15%
Advancing Care Information: 25%
Cost: 10%

- Replaces PQRS
- New Category
- Replaces the Medicare EHR Incentive Program (Meaningful Use)
- Replaces the Value Based Modifier.
## MIPS YEAR 2 PERFORMANCE PERIOD

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>2017 Minimum Performance Period</th>
<th>2018 Minimum Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>90-days</td>
<td>90-days</td>
</tr>
<tr>
<td></td>
<td>90-days</td>
<td>90-days</td>
</tr>
<tr>
<td></td>
<td>90-day minimum; full year was an option</td>
<td>12-months</td>
</tr>
<tr>
<td></td>
<td><em>Not included. 12-months for feedback only.</em></td>
<td>12-months</td>
</tr>
</tbody>
</table>
WHAT IS THE MINIMUM PARTICIPATION TO AVOID THE PENALTY?

To avoid the -5% payment adjustment in 2020 you must submit a 15 point minimum final score equal to the performance threshold. This has increased from a 3 point minimum in 2017.
## WHAT SCORE DO I NEED TO GET THE MAXIMUM PAYMENT ADJUSTMENT?

<table>
<thead>
<tr>
<th>2017 Final Score</th>
<th>2017 Payment Adjustment</th>
<th>2018 Final Score</th>
<th>Change</th>
<th>2018 Payment Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 70 points</td>
<td>Positive Adjustment – Eligible for exceptional performance bonus – minimum of additional 0.5%</td>
<td>≥ 70 points</td>
<td>No</td>
<td>Positive Adjustment greater than 0% – Eligible for exceptional performance bonus – minimum of additional 0.5%</td>
</tr>
<tr>
<td>4 - 69 points</td>
<td>Positive Adjustment – Not Eligible for exceptional performance bonus</td>
<td>15.01 - 69.99 points</td>
<td>Yes</td>
<td>Positive Adjustment greater than 0% – Not Eligible for exceptional performance bonus</td>
</tr>
<tr>
<td>3 points</td>
<td>Neutral Payment Adjustment</td>
<td>15 points</td>
<td>Yes</td>
<td>Neutral Payment Adjustment</td>
</tr>
<tr>
<td>0 points</td>
<td>Negative payment adjustment of -4% - 0 points = does not participate</td>
<td>3.76 - 14.99 points</td>
<td>Yes</td>
<td>Negative payment adjustment greater than 0% and less than 5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0 – 3.75 points</td>
<td>Yes</td>
<td>Negative payment adjustment of -5% - 0 points = does not participate</td>
</tr>
</tbody>
</table>
QUALITY – WHAT HAS CHANGED?

- Quality is 50% of your composite MIPS score in 2018 compared to 60% in 2017

- Data completeness is increasing from 50% in 2017 to 60% in 2018
  - Measures that do not meet requirement will earn 1 point in 2018 instead of 3 points in 2017
QUALITY – WHAT HAS STAYED THE SAME?

- Select up to 6 measures to report on
- 3 point floor for measures scored against a benchmark
- Receive 3 points maximum for measures that don’t have a benchmark or don’t meet the 20 case minimum
- Bonus for additional high priority measures up to 10% of denominator for performance category.
- Bonus for end-to-end electronic reporting up to 10% of denominator for performance category
QUALITY- TOPPED-OUT MEASURES

▲ Topped-out measures to be removed and scored on 4 year phase out timeline.

▲ Topped out measures with benchmarks that have been topped out for 2 consecutive years will earn up to 7 points

6 identified measures:
• CMS 21 - Perioperative Care: Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin
• CMS 224 – Melanoma: Overutilization of Imaging Studies in Melanoma
• CMS 23 – Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis
• CMS 359 – Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography
• CMS 262 – Image confirmation of Successful Excision of /image-Localized Breast Lesion
• CMS 52 - Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy
QUALITY IMPROVEMENT SCORING

The improvement percent score is awarded based on the rate of increase in the Quality performance category achievement percent score of MIPS eligible clinicians from the previous performance period to the current performance period.

Improvement percent score =
\[
\frac{\text{increase in the performance category score from the prior performance period}}{\text{current performance period category score}} \times 10\%
\]

The improvement score may not total more than 10 percentage points or lower than 0 percentage points.
COST

- 10% of final score for 2020 payment year

- Score will be calculated using administrative claims data if they meet the case minimum and if a benchmark has been calculated for a measure

- Measures
  - Medicare Spending per Beneficiary (MSPB)
  - Total Per Capita Cost for all attributed beneficiaries

- The 10 episode-based measures adopted for 2017 will not be used in 2018
MEDICARE SPENDING PER BENEFICIARY (MSPB)

TIN’s specialty-adjusted MSPB Measure

\[
\text{TIN's specialty-adjusted MSPB Measure} = \frac{\text{TIN's average MSPB amount}}{\# \text{ of episodes for that TIN}} \times \text{(National average standardized episode cost)}
\]

Where TIN’s average MSPB amount = \( \sum \) of standardized, risk-adjusted spending across all eligible episodes.

An MSPB episode includes all Medicare Part A and Part B claims with a start date falling between 3 days prior to an Inpatient Prospective Payment System (IPPS) hospital admission (also known as the “index admission” for the episode) and 30 days after hospital discharge.
TOTAL PER CAPITA COST FOR ALL ATTRIBUTED BENEFICIARIES

The outcome for this measure is the sum of Medicare Part A and Part B costs for each beneficiary. Costs are payment standardized, annualized, risk adjusted, and specialty adjusted.

- In the 2017 QPP final rule, CMS added the transitional care management CPT codes (99495 and 99496) and a CCM code (99490) to the list of primary care services.
- In the CY 2017 Physician Fee Schedule, CMS changed the payment status for two existing CPT codes (99487 and 99489) that could be used to describe care management from B (bundled) to A (active).
- CMS added CPT codes (99487 and 99489) to the list of primary care services used to attribute patients under the total per capita cost measure for 2018.
COST PERFORMANCE SCORING

Performance is compared against performance of other MIPS eligible clinicians and groups during the performance period so benchmarks are not based on a previous year.

The score will be calculated when the organization meets the minimum case requirement for the two measures:
• Medicare Spending Per Beneficiary (MSPB) – 35
• Total Per Capita Cost for all attributed beneficiaries – 20

Performance category score is based on the average of the two measures.

If only one measure can be scored, that measure will be the performance category score.
The improvement percent score is determined by comparing the number of measures with statistically significant change in performance.

Cost Improvement Score =

\[
\frac{\text{# of cost measures with a significant decline} - \text{# of measures with significant improvement}}{\text{# of cost measures the MIPS clinician was scored for 2 consecutive years}}
\]

- This fraction is then multiplied by the maximum improvement score
- The improvement score may not total more than 1 percentage point or lower than 0 percentage points.
COST CATEGORY SCORE

Cost performance category percent score =

\[
\frac{\text{the total number of achievement points}}{(\text{the total number of available achievement points} + \text{the cost improvement score})}
\]

This score does not exceed 100 %

*A cost performance category score is not calculated if a MIPS eligible clinician has not attributed any cost measures because they did not meet the case minimum or a benchmark has not been created for the measure.
PREPARING FOR THE COST CATEGORY

⚠️ Review your prior year QRUR report to understand your historical performance.
  • These measures have been used since 2016.

⚠️ Analyze your 2017 cost performance category as soon as it becomes available as it will be used for the basis for calculating improvement scoring for the 2018 cost category performance score.
  • CMS intends to have feedback available by July 1, 2018.
IMPROVEMENT ACTIVITIES

- Remains at 15% of composite score for 2018
- Total available measures ↑ from 92 to 112
- Small practices (15 or less clinicians) can continue to submit 2 measures
- 50% threshold for the number of practice sites within a TIN that need to be patient-centered medical homes for that TIN to get full credit for the Improvement Activities performance category
- For group participation, only 1 MIPS eligible provider has to perform the activity for the TIN to get credit
Remains 25% of your composite score
No change to Base Score requirements
Earn 10% bonus if you only use the 2015 Edition CEHRT (can still use 2014 CEHRT)
Earn 10% in the performance score for reporting any single public health agency or clinical health data registry
Earn 5% bonus for submitting to an additional public health agency or clinical data registry not reported under the performance score
Additional Improvement Activities are eligible for a 10% ACI bonus if using CEHRT to complete at least 1 of the specified Improvement Activities
For the 2017 and 2018 reporting period CMS added exclusions for:

- Health Information Exchange Measure
  - Any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period may exclude from the measure.

- E-Prescribing Measure
  - Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period may exclude from the measure.
Clinicians can earn up to 5 bonus points for the treatment of complex patients (based on a combination of the Hierarchical Condition Categories (HCCs) and number of dually eligible patients treated).

- An average HCC score is calculated based on the calendar year immediately prior to the performance period.
- Indicators used for complexity:
  - Medical complexity as measured through Hierarchical Condition Category risk scores
  - Social Risk as measured through the proportion of patients with dual eligible status (Medicare & Medicaid)

Complex patient bonus =

\[(\text{average HCC risk score} + \text{dual eligible ratio (based on full and partial benefit beneficiaries)}) \times 5\]
A small practice bonus of **5 points** will be added to the final score for the 2020 MIPS payment year for MIPS eligible clinicians, groups and virtual groups and APM Entities who participate in MIPS by submitting data on at least one performance category in the 2018 MIPS performance period.
HARDSHIP EXEMPTIONS

Based on the 21st Century Cures Act, CMS will reweight Advancing Care Information to 0% of the final score and reallocate the 25% performance category weight to Quality for:

• A significant hardship exemption
• A new hardship exemption for MIPS eligible clinicians in small practices
• An exemption for hospital based MIPS eligible clinicians
• A new exemption for Ambulatory Surgical Center – based MIPS eligible clinicians
• A new exception for MIPS eligible clinicians who’s EHR was decertified
AUTOMATIC EXTREME & UNCONTROLLABLE CIRCUMSTANCE POLICY

For clinicians directly affected by natural disasters to include hurricanes Harvey, Marie and Irma, CMS established an interim final rule to reweight the advancing care information, quality and improvement activities performance categories to zero for the transition year resulting in a final score equal to the performance threshold without clinicians having to submit an application.

- Clinicians can still submit MIPS data which would then be scored like all other MIPS clinicians.
There are 3 ways to participate in MIPS

- Individual-level reporting
- Group-level reporting
  - 2 or more providers within the same TIN
- Virtual group-level reporting (new to 2018)
  - 2 or more TINs
VIRTUAL GROUPS

Virtual groups are a combination of 2 or more TINs consisting of solo practitioners or groups (consisting of less than 10 clinicians) that elect to report as a virtual group for the entire reporting period.

- MIPS payment adjustments would only apply to MIPS eligible clinicians in the group
- Groups can consist of clinicians of any specialty from any geographic location on any CEHRT
- Small practice eligible clinicians that are part of a Virtual groups of 16 or more clinicians will not identify as a small practice status within the group.

Deadline for a representative to make election to report as a virtual group is **December 31, 2017** for the 2018 reporting period.
VIRTUAL GROUP REPORTING

The group would be scored across all 4 MIPS categories:

- **Improvement Activities** – would meet the group-related requirements if at least one NPI within the virtual group completed an improvement activity for a minimum of a continuous 90-day period within 2018.

- **Advancing Care Information** – would need to fulfill the required base score measures for a minimum of 90 days and additionally can submit performance score measures and bonus score measures.

- **Quality** – would report on the same 6 measures for the performance category.

- **Cost** – performance will be assessed in a manner that applied the combined performance of all MIPS eligible clinicians in the virtual group.
LOGGING IN TO REPORT FOR 2017 AND BEYOND

⚠️ You will be reporting via the Quality Payment Program website. This section of the site has been made available yet.

⚠️ The QPP website will use the same login used on the CMS Enterprise Portal site. Update your username and password now! https://portal.cms.gov/wps/portal/unauthportal/home/