Medicare Quality Payment Program:

Advanced APMs and MIPS

January 19, 2017

Heart of America HIMSS

MACRA and the QPP

VBR Framework

FEE-FOR-SERVICE (FFS) PAYMENTS

- A *Traditional FFS*
- B *Infrastructure Incentives*
- C *Care Management Payments*

ADJUSTED FFS PAYMENTS

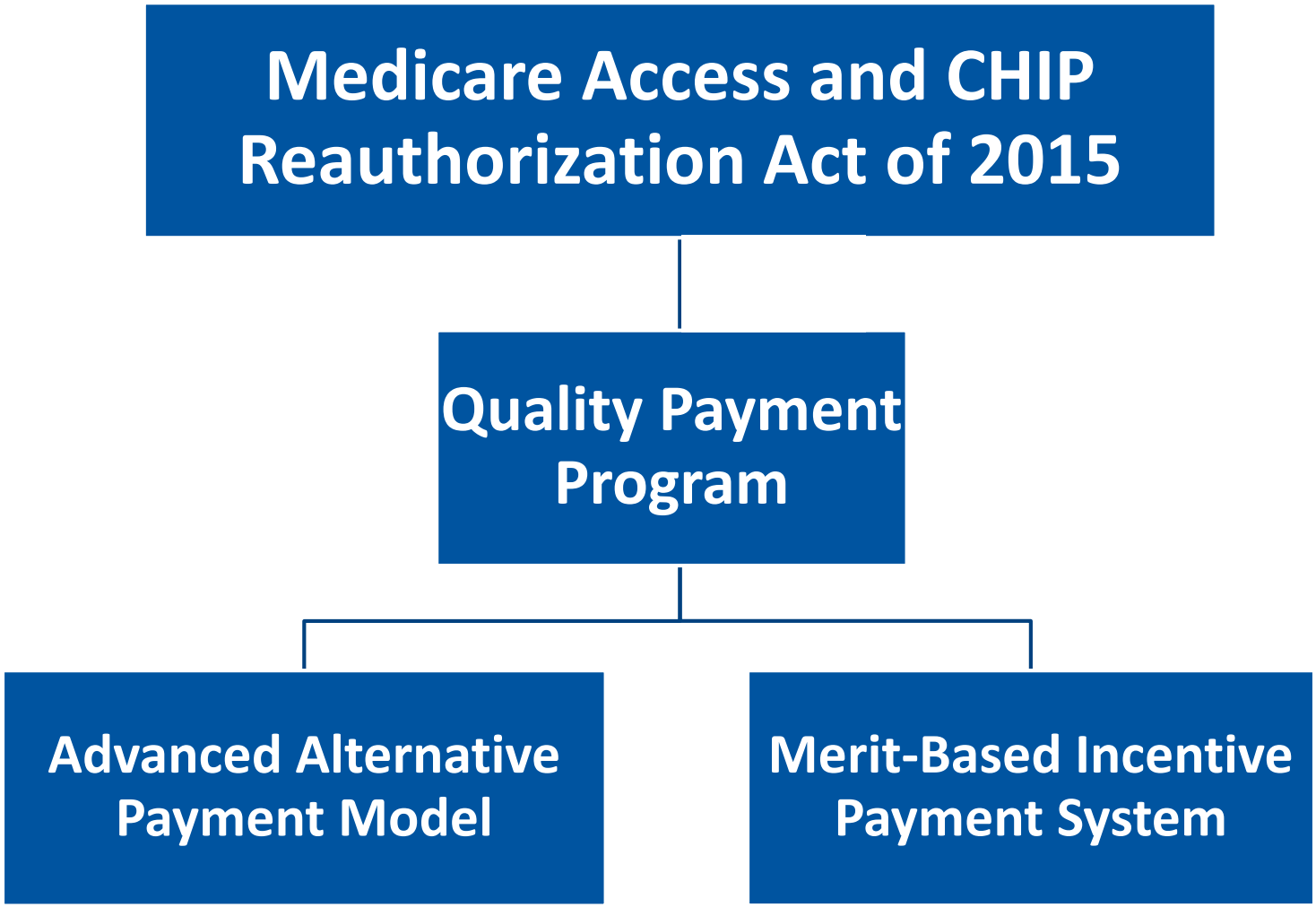
- A *Pay For Reporting*
- B *Pay For Performance*
- C *Pay/Penalty For Performance*

APMs INCORPORATING FFS PAYMENTS

- A *Total Cost of Care Shared Savings*
- B *Total Cost of Care Shared Risk*
- C *Retrospective Bundled Payment*
- D *Prospective Bundled Payment*

POPULATION-BASED APMs

- A *Condition-Specific Population-Based Payments*
- B *Primary Care Population-Based Payments*
- C *Comprehensive Population-Based Payments*



Eligible Clinicians

Years 1 and 2	Years 3+
	
Physicians (MD/DO, DPM, OD, DC, DMD/DDS) **PAs, APRNs, CNSs, CRNA**	**Physical or occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, dieticians/nutritional professionals**

Advanced APMs

Advanced APMs (Traditional Medicare)

Definite
Medicare Shared Savings Program (Tracks 2 & 3 Only)
Next Generation ACO Model
Comprehensive ESRD Care (LDO arrangement and Two-Sided Risk)
Comprehensive Primary Care Plus (re-open applications)
Oncology Care Model (Two Sided Risk)

In Development
Medicare Shared Savings Program Track 1+
Comprehensive Care for Joint Replacement (CEHRT Track)
Episodic Payment Model (CEHRT and non-CEHRT Tracks)
Cardiac Rehabilitation Incentive Payment Model
Medicare Diabetes Prevention Program
New Voluntary Bundled Payment Program
Vermont Medicare ACO Initiative

Qualifying Participant

Qualifying Participant

- Higher % of patients or payments
- Bonus = 5% of MPFS payments

Partial Qualifying Participant

- Lower % of patients or payments
- No bonus, no MIPS

Non-Qualifying Participant

- Subject to MIPS

Medicare Option – Payment Amount Threshold

Payment Year	2019	2020	2021	2022	2023	2024
QP Threshold	25%	25%	50%	50%	75%	75%
Partial QP Threshold	20%	20%	40%	40%	50%	50%

Medicare Option – Patient Count Threshold

Payment Year	2019	2020	2021	2022	2023	2024
QP Threshold	25%	25%	50%	50%	75%	75%
Partial QP Threshold	20%	20%	40%	40%	50%	50%

Other Payer Advanced APMs

- Credit for participation in Other Payer Advanced APMs starting in 2019
  - Three criteria: (1) **Use of CEHRT**; (2) **Quality measures**; and (3) **More than nominal financial risk *or* medical home model**
  - Submission and approval process
- Still requires some level of participation in Advanced APMs

All Payer Combination Option – Payment Amount Threshold

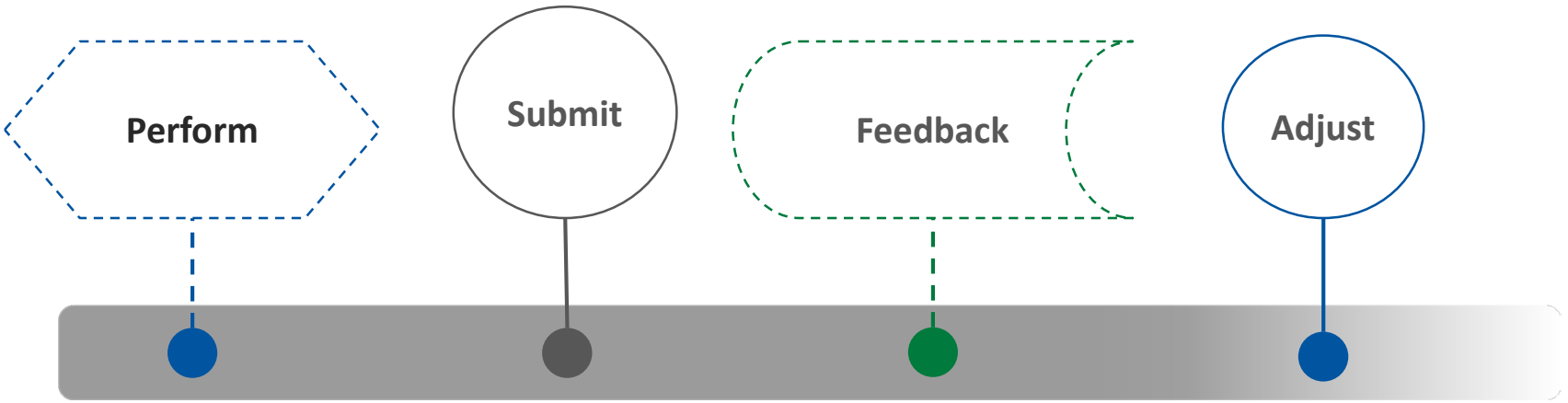
Payment Year	2019	2020	2021		2022		2023		2024	
	MCR	MCR	Total	MCR	Total	MCR	Total	MCR	Total	MCR
QP Threshold	-	-	50%	25%	50%	25%	75%	25%	75%	25%
Partial QP Threshold	-	-	40%	20%	40%	20%	50%	20%	50%	20%

All Payer Combination Option – Patient Count Threshold

Payment Year	2019	2020	2021		2022		2023		2024	
	MCR	MCR	Total	MCR	Total	MCR	Total	MCR	Total	MCR
QP Threshold	-	-	35%	20%	35%	20%	50%	20%	50%	20%
Partial QP Threshold			25%	10%	25%	10%	35%	10%	35%	10%

MIPS

Performance-To-Adjustment Cycle

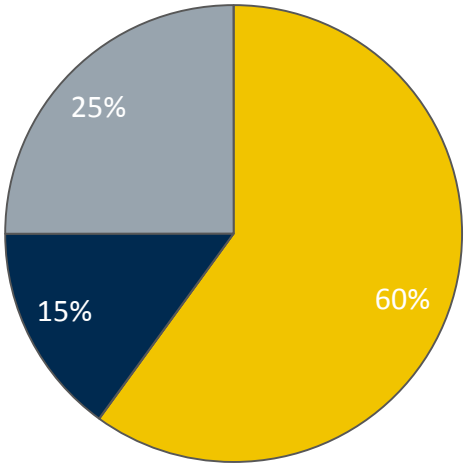


CY 2017	March 31, 2018	Q3 2018	CY 2019
Period of time for which performance will be evaluated *2017 only: may elect 90-day continuous performance period*	Deadline for individual/group to report on required measures	CMS reports on prior year performance, including calculation of Final Score and payment adjustment for upcoming year	Positive or negative MPFS payment adjustments based on 2017 Final Score

MIPS Final Score Components

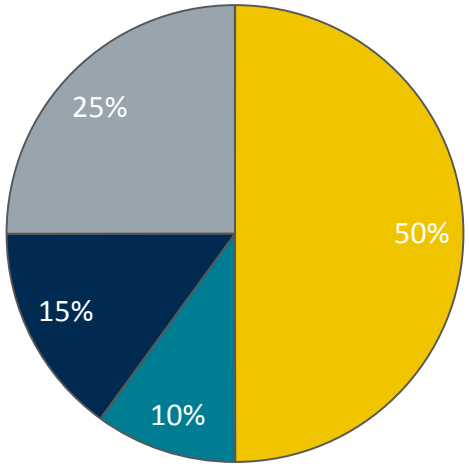
Quality	Improvement Activities	Advancing Care Information	Cost Performance

2017 Performance Year



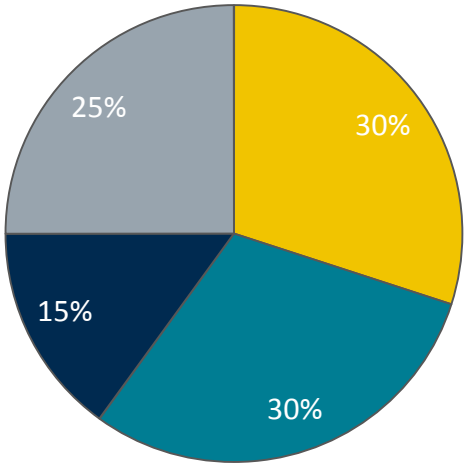
Impacts 2019 Payments

2018 Performance Year



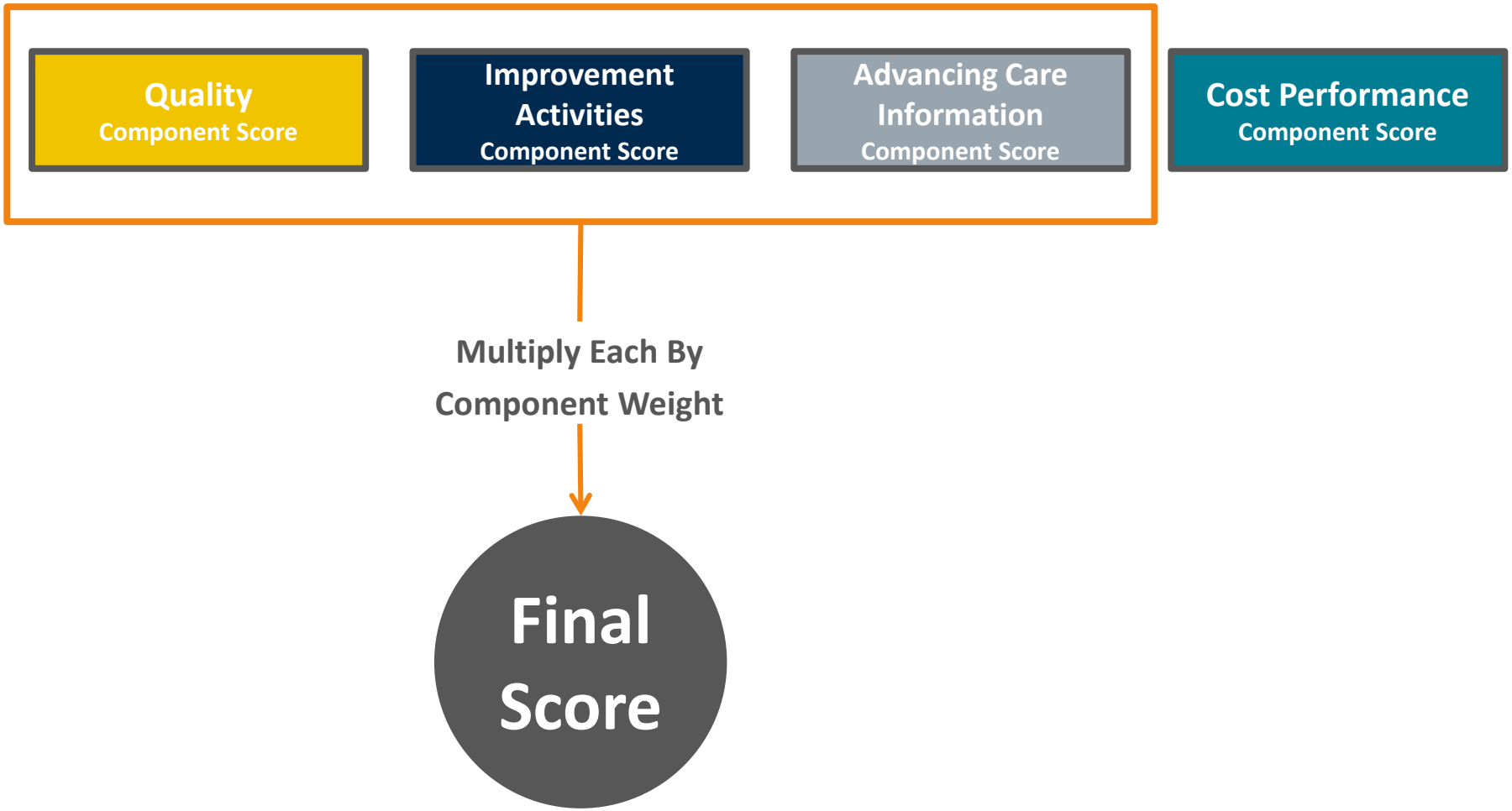
Impacts 2020 Payments

2019 Performance Year

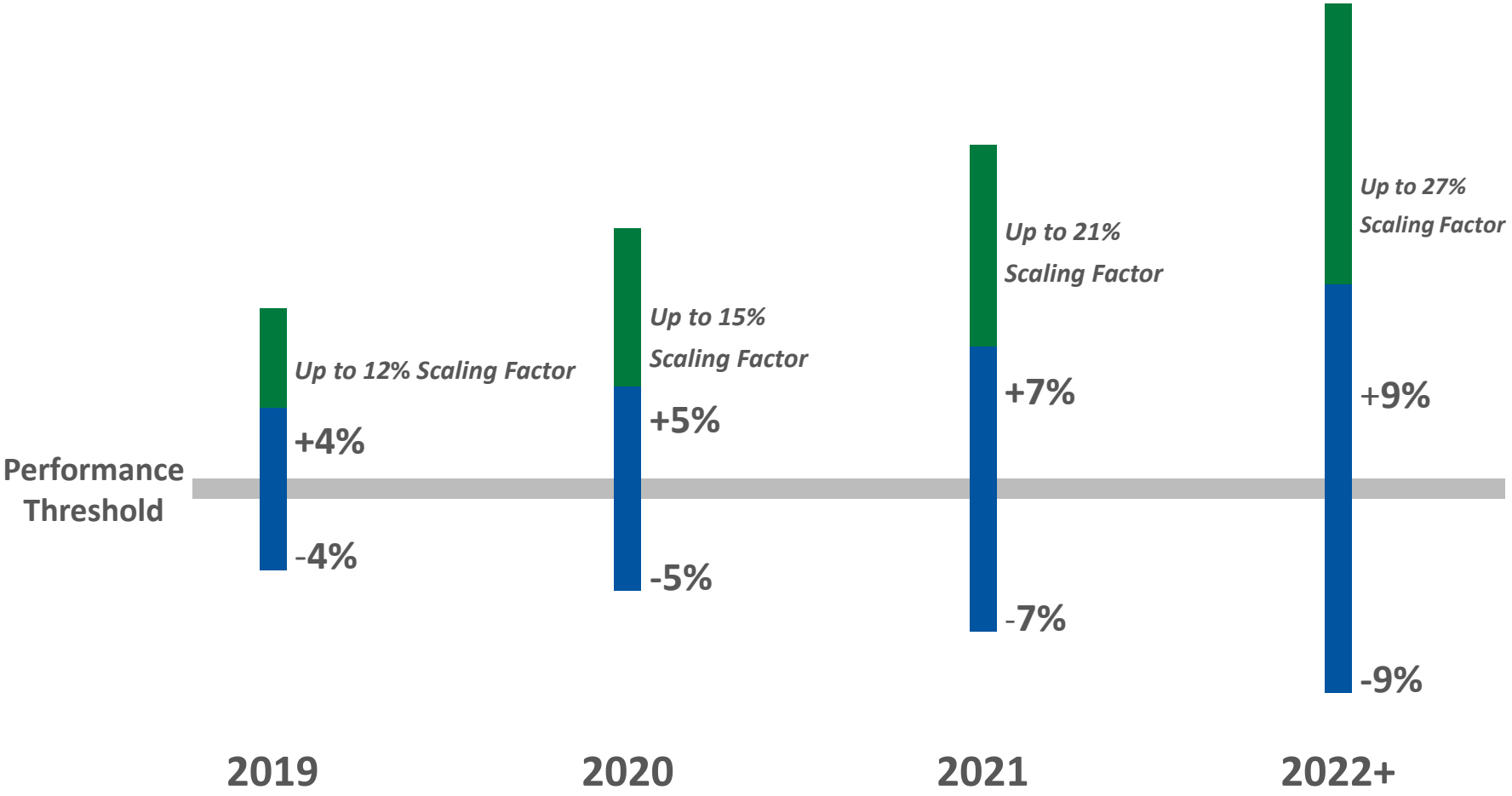


Impacts 2021 Payments

2017 Final Score Calculation

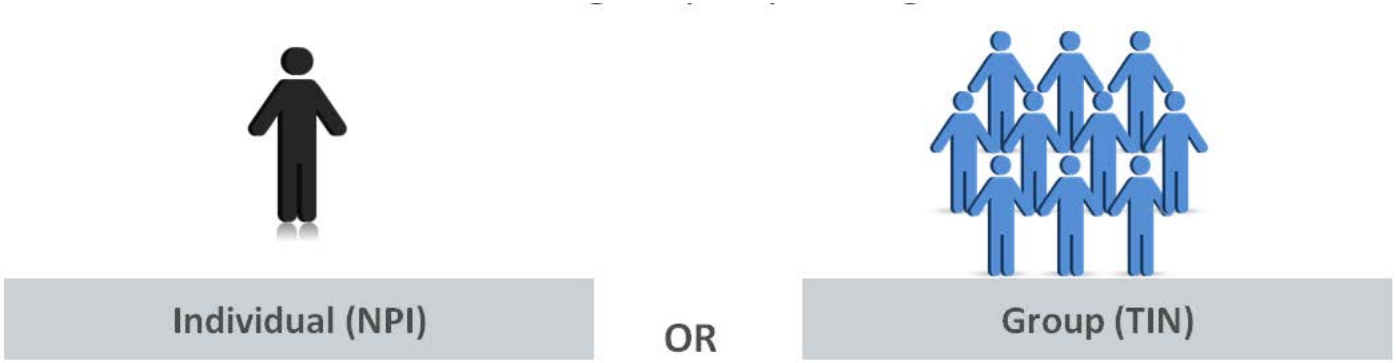


MIPS Payment Adjustments



Top performers share in $500 million bonus pool (not to exceed 10% of allowed charges)

MIPS Participation Election

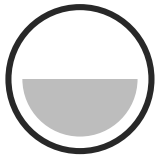
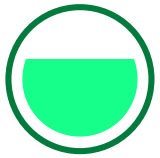
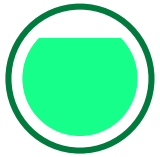


- Final Score assigned to each **NPI/TIN**
- Group reporting must include *all* NPIs who reassign to TIN; cannot pick and choose
- NPI who reassigns to TIN reporting as a group may also report individually (well, maybe…)

Low-Volume Threshold

- For 2017, individual or group exempt from MIPS if:
  - $30,000 or less in allowable Part B charges; **or**
  - See 100 or fewer traditional Medicare beneficiaries
- If elect group reporting, NPIs who would be exempt if reporting individually are NOT exempt
- Two determination periods (both with 60-day claims run-out)
  - September 1, 2015, to August 31, 2016
  - September 1, 2016, to August 31, 2017

2017: Pick Your Pace

	2017 Reporting Option	2019 Payment Impact
	No reporting	4 percent penalty on all MPFS payments
	Report performance for minimum of 90-day continuous period ✓ One quality measure OR ✓ One clinical practice improvement activity OR ✓ All required measures for advancing care information	No penalty, no bonus
	Report performance for minimum of 90-day continuous period ✓ More than one quality measure OR ✓ More than one clinical practice improvement activity OR ✓ More than the required measures for advancing care information	Eligible for up to 12% bonus on all MPFS payments (amount varies based on Final Score and budget-neutral scaling factor)
	Report performance s on all required measures for minimum of 90-day continuous period.	Eligible for up to 12% bonus on all MPFS payments (amount varies based on Final Score and budget-neutral scaling factor) If Final Score ≥ 70, eligible for additional Exceptional Performance Bonus (amount varies based on Final Score and distribution of $500 million annual fund; cannot exceed 10% of Part B allowed charges)

MIPS Components

Reporting Requirements and Scoring Methodology

PYA

Quality Reporting

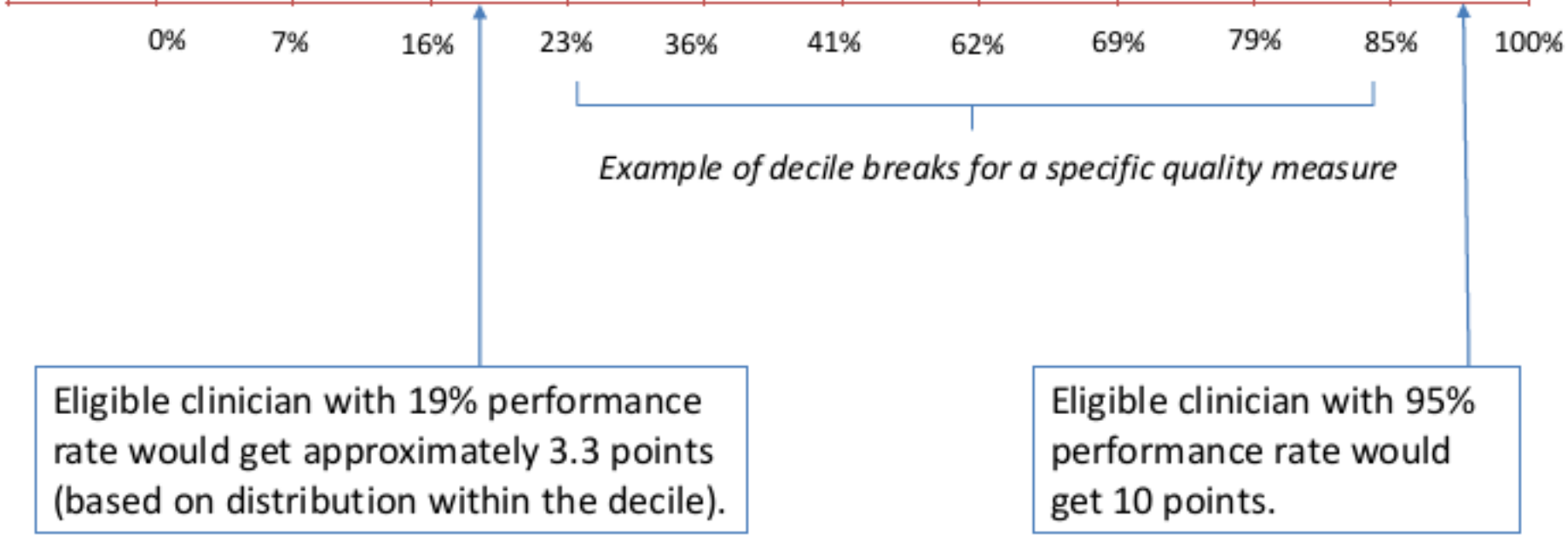
Manner of Participation	Reporting Mechanism	Measure Requirements	Data Completeness
Individual	Part B Claims	6 measures (at least 1 outcome measure) OR specialty-specific measure set (including oncology)	50% of Part B patients (60% in 2018)
Individual or Group	QCDR Qualified Registry EHR	6 measures (at least 1 outcome measure) OR specialty-specific measure set (including oncology)	50% of individual's or group's patients who meet measure denominator (60% in 2018)
Group	CMS Web Interface (register by 06/30/17)	All measures included	CMS-selected sample of Part B patients

Quality Scoring Methodology

- **Measure No. 7: All-Cause Readmissions**
  - CMS calculates using claims data; minimum 200 cases
  - Group or NPI/TIN based on participation election
- **Point conversion**
  - CMS calculates deciles for each measure based on nat'l performance in baseline period
  - Compare score to decile breaks and assign corresponding points
  - Assign zero points for unreported measures
  - If report more than required # of measures, CMS uses top points to calculate quality component score
- **Bonus points**
  - 1 extra point for each measure reported using CEHRT for end-to-end electronic reporting up to 10% of total possible points
  - 2 points for add'l outcome/ patient experience measure; 1 point for other high priority measures up to 10% of total possible points
- **Quality component score**
  - Total points on 7 measures + bonus points
  - Adjusted based on measures with insufficient # of cases

Point Assignment Based on Deciles

DECILE	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Possible POINTS	1.0-1.9	2.0-2.9	3.0-3.9	4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10



1)

2017 Quality Measure Benchmarks

Table 1. Sample Quality Measure and Performance Thresholds

Measure Name	Submission Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Topped Out
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (#226)	Claims	95.60 - 97.85	97.86 - 99.25	99.26 - 99.99	--	--	--	--	100	Yes
	EHR	72.59 - 81.59	81.60 - 86.68	86.69 - 90.15	90.16 - 92.64	92.65 - 94.67	94.68 - 96.58	96.59 - 98.51	>= 98.52	No
	Registry/ QCDR	76.67 - 85.53	85.54 - 89.87	89.88 - 92.85	92.86 - 95.14	95.15 - 97.21	97.22 - 99.10	99.11 - 99.99	100	No

Source: CMS Quality Measure Thresholds for 2017 MIPS Reporting (qpp.cms.gov)

Improvement Activities Reporting

90+ Improvement Activities Across 9 Subcategories Each Graded Medium (10 pts) or High (20 pts)
Expanded Practice Access
Population Management
Care Coordination
Beneficiary Engagement
Patient Safety and Practice Assessment
Participation in an APM
Achieving Health Equity
Integrated Behavioral and Mental Health
Emergency Preparedness and Response

Improvement Activities Scoring

Most Participants	→	**Attest to completion of 4 activities for minimum of 90 days**
Groups (a) with fewer than 15 participants, (b) located in rural area or HPSA	→	**Attest to completion of 2 activities for minimum of 90 days**
Participants in certified PCMH or comparable specialty practice designation	→	**Full credit**
Participants in MIPS APM	→	**Full credit**
Participants in other APMs	→	**Half credit**

*

Improvement Activities Component Score (capped at 100) =

(# of **Medium** Activities * 10) + (# of **High** Activities * 20) / 40 possible points

Advancing Care Information Reporting

Base Score Measures (All or Nothing – 50 points)	Performance Score Measures (0 to 10 points each based on percentage)
Security Risk Analysis	Patient Specific Education
E-Prescribing	View, Download, or Transmit
Provide Patient Electronic Access	Provide Patient Electronic Access*
Health Information Exchange	Health Information Exchange*
	Medication Reconciliation
	Secure Messaging
	Immunization Registry Reporting (Y/N)

*Select measures worth up to 20 points towards performance score.

Advancing Care Information Scoring

50-point Base Score +

0- to 90-point Performance Score +

Up to 15 Bonus Points =

(syndromic surveillance, electronic case, public health registry, and clinical data registry reporting; reporting improvement activities using CEHRT)

Up to 100 points

Cost Performance Component

- Not included in 2017 Final Score calculation, but feedback provided
- No additional reporting; CMS calculate from claims data
- Two categories of measures (attribution)
  - Two total cost of care measures
    - Total per capita costs
    - Medicare Spending Per Beneficiary
  - Ten episode-based efficiency measures
    - Reported in 2014 supplemental QRUR
- Scored on deciles (like quality component)

1)

Patient Relationship Categories

- MACRA-mandated tools to compare relative cost performance among eligible clinicians/groups
- Begin including codes on claims no later than 01/01/2018
- CMS to publish codes in April 2017
  - Continuing care relationship
  - Acute care relationship
  - Care furnished pursuant to order from other practitioner

1)

Final Score Calculation

- Sum of each of the products of each component score and each component's assigned weight, multiplied by 100.
- Example:
  - Quality = (55 points / 70 possible points) x 60%
  - Advancing Care Information = (84 points / 100 possible points) x 25%
  - Improvement Activities = (40 points / 40 possible points) x 15%
  - **FINAL SCORE = 83.14**

APM Scoring Standard

- Applies to those eligible clinicians identified on MIPS APM participant list
  - MIPS APM
    - Advanced APMs
    - Track 1 MSSP ACO
    - Oncology Care Model (one-sided model)
  - Included on participant list as of March 31, June 30, **or** August 31 of performance year

Applying the APM Scoring Standard

- 50% Quality
  - Based on APM performance measures
- 20% Improvement Activities
  - Full Credit
- 30% Advancing Care Information
  - Weighted mean average of APM participants' reported scores

1)

Game Plan

Public Reporting

- Individual profile pages
  - Participation in APM
  - Final Score
  - Component scores
- Aggregate data
  - Range of Final Scores and component scores

Action Items

- ✓ Education
- ✓ Group vs. individual reporting
- ✓ Pick-Your-Pace
- ✓ Quality measure selection and corresponding performance improvement (workflow changes/data collection)
- ✓ Improvement activities selection and execution
- ✓ “Meaningful Use”
- ✓ Reporting mechanism(s)
- ✓ Preparation for cost performance measures
- ✓ Future APM participation

Thank You!

Martie Ross

Principal, PYA

mross@pyapc.com

(913) 748-4604