


**MACRA ESSENTIAL STRATEGIES**  
 Adele Allison, Director of Provider Innovation Strategies  
 September 14, 2017



MASTER COMPLEXITY™

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**AUDIENCE ENGAGEMENT**

- Take out your smartphone
- Login to [Pollev.com/adele](http://Pollev.com/adele)
- On word clouds, please text answers in single responses (e.g., SingleResponses)


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### AGENDA

- Value-Based Payment (VBP)
- MACRA Rule-Making
- Merit-based Incentive Payment System
- Advanced APMs
- Essential Strategies
- Questions

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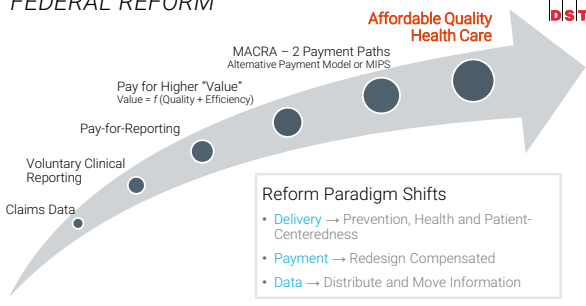
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### FEDERAL REFORM



MACRA – 2 Payment Paths  
Alternative Payment Model or MIPS

Pay for Higher "Value"  
Value = f(Quality + Efficiency)

Pay-for-Reporting


Voluntary Clinical Reporting

Claims Data

Affordable Quality Health Care

**Reform Paradigm Shifts**

- **Delivery** → Prevention, Health and Patient-Centeredness
- **Payment** → Redesign Compensated
- **Data** → Distribute and Move Information



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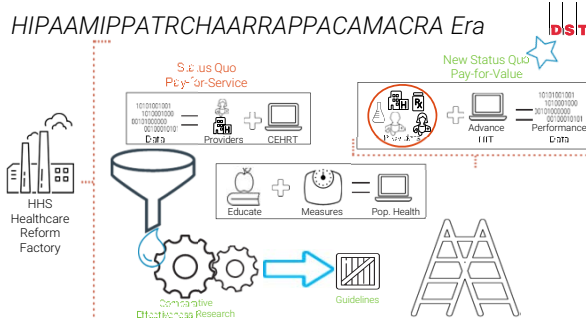
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### HIPAA MIP PATR CHA ARR APPACAMA CRA Era



HHS Healthcare Reform Factory


Old Status Quo: Pay-for-Service  
Providers + CEHRT

New Status Quo: Pay-for-Value  
Advance HIT + Performance Data

Competitive Bidding Research

Educate + Measures = Pop. Health

Guidelines



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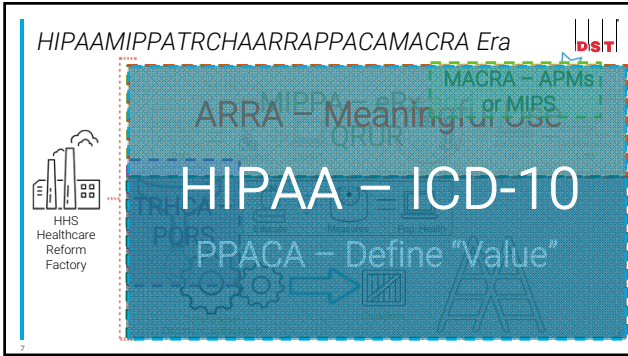
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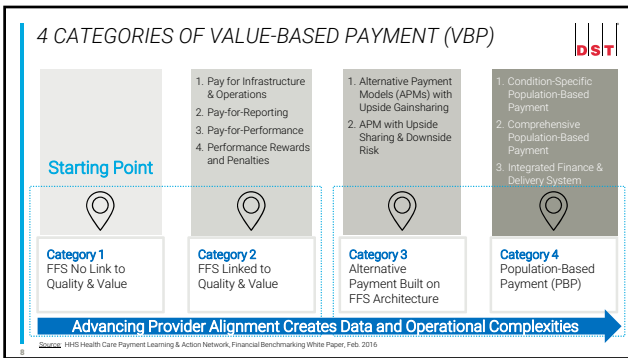
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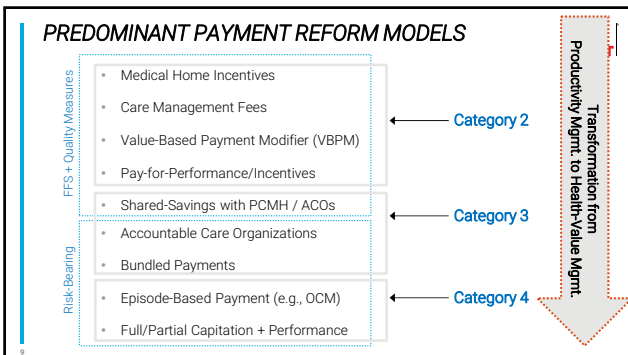
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MACRA BY THE NUMBERS D|S|T

- 95 – Pages long
- 31 – “Reasonable Cost Reimbursement”
- 18 – Risk
- 27 – EHR or Technology to Manage, Measure and Report
- 8 – Meaningful Use
- 38 – Quality Measures
- 19 – Resource Use or Efficiency
- 171 – “Measures” or “Measurement”
- 103 – Data



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PREDOMINANT PAYMENT REFORM MODELS D|S|T

FFS + Quality Measures

- Medical Home Incentives
- Care Management Fees
- Value-Based Payment Modifier (VBM)
- Pay-for-Performance/Incentives

Risk-Bearing

- Shared-Savings with PCMH / ACOs
- Accountable Care Organizations
- Bundled Payments
- Episodes of Care Groupers
- Full/Partial Capitation + Performance

**MACRA**  
Quality Payment Program (QPP)

← **Category 2**  
Merit-Based Incentive Payment System (MIPS)  
(2017 Perform, 2019 Payment)

← **Category 3**  
Advanced APM (A-APM)

← **Category 4**

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
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### FINAL RULE – 2017 TRANSITION YEAR



| Options      | 1 MIPS – Penalty Avoidance   | 2 MIPS – Delayed Start  | 3 MIPS – Ready to Go   | 4 Advanced Alternative Payment Model   |
|--------------|--|---|--|--|
| Requirements | <b>Submit by Mar. 31, 2018</b><br>– 90 days of data between Jan. 1 and Oct. 2, 2017<br>– 1 Quality Measure, Improvement Activity, or 5 required Advancing Care Information measures<br> | <b>Submit by Mar. 31, 2018</b><br>– 90 days of data between Jan. 1 and Oct. 2, 2017<br>– > 1 Quality Measure, and/or<br>– > 5 required Advancing Care Information measures<br> | <b>Submit by Mar. 31, 2018</b><br>– “Full Year” of data<br>– 6 Quality Measures (1 outcome) – MIPS APM Groups report 15;<br>– 4 improvement activities, or 2 for small, rural, HPSA or non-patient facing<br>– Required or up to 9 of advancing care information measures<br> | <b>Significant portion of Medicare patients or payments</b><br>– Qualified Participant (QP) determination “snapshot” and inclusive<br>– Driven by patient or pay thresholds<br> |

CMS, Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models. Final Rule Released to Office of Federal Register, October 14, 2016.

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### MACRA 2018 PROPOSED RULE – PRICE IS RIGHT?



- 2018 proposed rule released June 20<sup>th</sup>
- Comment period ended Aug. 21<sup>st</sup> → Oct/Nov Final Rule
- CMS Rule theme → “Reduce the Burden”
- Increased “low volume” threshold → solo & small groups (< 10) exemptions
- CMS Fact Sheet: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Proposed-rule-fact-sheet.pdf>




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### QPP HIGH-LEVEL 2018 PROPOSAL



| QPP Area   | Flexibility Policy   |
|--|--|
| <b>Merit-based Incentive Payment System (MIPS)</b> |  |
| <b>Strengthening Referral Paths</b>                | “Virtual Group” option   |
| <b>Low-Volume Thresholds</b>                       | Exemption if Medicare Part B volume is ≤ \$90,000 or fewer than ≤ 200 patients (2018); possibly adding # of billed services/items by 2019  |
| <b>EHR</b>   | Allow 2014 CEHRT, Encourage 2015 CEHRT   |
| <b>Bonus Points</b>                                | Complex Patients, 2015 Edition CEHRT   |
| <b>Quality Scoring</b>                             | Incorporate performance improvement in calculation   |
| <b>Facility-based Clinicians</b>                   | Facility-based scoring option  |
| <b>Small Practice Clinicians</b>                   | <ul style="list-style-type: none"> <li>• Hardship exception under Advancing Care Information</li> <li>• Bonus point to the final score</li> <li>• 3-Points under quality performance when data completeness not met</li> </ul> |
| <b>Advanced Alternative Payment Model (A-APM)</b>  |  |
| <b>Nominal Amount of Risk Standard</b>             | <ul style="list-style-type: none"> <li>• Extend the 2 year rate – 8% of Medicare A &amp; B – for an additional 2 years until 2020</li> <li>• Slow the increasing of risk amount for Medical Homes</li> </ul>                   |
| <b>All-Payer Combination Option</b>                | Additional details set forth for PY2019  |
| <b>APM Scoring Standard</b>                        | Reduced burden for MIPS APM participants   |

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MIPS COMPOSITE PERFORMANCE SCORE D|S|T

| Performance Year / Application Year | Quality Measures   | Resource Use or Cost                      | Improvement Activities  | Advancing Care Information   |
|-------------------------------------|--|---|---|--|
| <b>Description</b>                  | Replaces CMS Physician Quality Reporting System (PQRS)   | Replaces ACA Value-based Payment Modifier | New category of measurement; Medical Homes and NCQA PCSR receive full credit; 93 activities available | Replaces CMS EHR Incentive Programs /N/A Meaningful Use;                       |
| <b>Reporting Methods</b>            | Claims, CSV, Web Interface (for group reporting), EHR, Qualified Clinical Data Registry (QCDR) | Claims                                    | Attestation, QCDR, Qualified Registry, EHR Vendor, Web Interface                                      | Attestation, QCDR, Qualified Registry, EHR Vendor, Web Interface (groups only) |
| 2017 / 2019                         | 60%  | 0%*                                       | 15%   | 25%  |
| 2018 / 2020                         | 60%  | 0%*                                       | 15%   | 25%  |
| 2019 / 2021                         | 30%  | 30%                                       | 15%   | 25%  |

\*Measured for feedback only in 2017; 2018 Proposed Rule Value

CMS Medicare Program Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, Final Rule, Released to Office of Federal Register, October 13, 2017

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CMS RESOURCES D|S|T



**Help!**

URL: <https://apps.cms.gov/>

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**MIPS – CPS PAYMENT ADJUSTMENTS** 

- Positive / Negative adjustments are CMS budget neutral
- Scoring → "Points" earned under each category, 0-100 points
- Eligible Clinicians (ECs) → perform all or none of categories
- ECs performing none → Composite Performance Score (CPS) of zero and subject to maximum negative adjustment

| Final Score Points | MIPS Adjustment   |
|--------------------|---|
| 0.0 – 0.75         | Negative 4 percent  |
| 0.76 – 2.9         | Negative MIPS payment adjustment > -4.0% and < 0.0% on a linear sliding scale   |
| 3.0                | 0.0% adjustment   |
| 3.1 – 69.9         | Positive MIPS payment adjustment > 0.0% to 4.0% x a scaling factor to preserve budget neutrality, on a linear sliding scale   |
| 70.0 – 100         | Positive MIPS payment adjustment of 4.0% AND additional MIPS bonus for "exceptional performance" of 0.5 percent to 10.0% on a linear sliding scale x scaling factor |

CMS, Medicare Program, Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, Final Rule, Table 31, Released to Office of Federal Register, October 14, 2016.

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**CMS APM vs. A-APM** 



CMS Alternative Payment Model (APM)



CMS Advanced Alternative Payment Model (A-APM)

There is a difference!

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2-PART QUALIFIER FOR A-APMs D|S|T



**1** Nominal Risk Standard



**2** Volume Threshold

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FINANCIAL REWARDS D|S|T

**3** • **Advanced APM**


- APM-specific Rewards
- Lump sum incentive of 5% of Medicare payments
- Qualified Participants (QPs) not subject to MIPS

**2** • **Non-advanced APM or MIPS APM**

- APM-specific Rewards
- MIPS Opt-In – Collective Scoring
  - Clinicians Scored Individually
  - Scores averaged across APM
  - Average score applied to all APM clinicians subject to MIPS
- MIPS Opt-Out – No Scoring

**1** • **Not in APM**

- MIPS Rewards (or penalties)



Earning more than fee schedule

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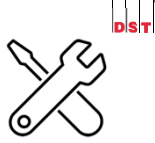
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ESSENTIAL STRATEGIES

- #1 Assess → Payers & Patient Health Status
- #2 Recognize → Majority Revenue Source
- #3 Identify → Essential Data Points
- #4 Communicate → Remember Claims = Reporting Data
- #5 Document → Clinical Documentation Improvement (CDI)
- #6 Redesign → Use "5-Rights" for Strong Data Capture
- #7 Align → Payers, Provider Community, Patients



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AND REMEMBER ...

**We're all in  
this together –  
by ourselves!**

- Lily Tomlin



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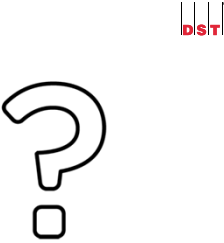
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THANK YOU

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 @Adele\_Allison



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