Advisory Board | Quality Reporting Roundtable

Get Straight on MACRA in 2018

FAQs, Advisory Board Guidance, and Resources

Ye Hoffman, MS, CPHIMS
Consultant

March 27, 2018

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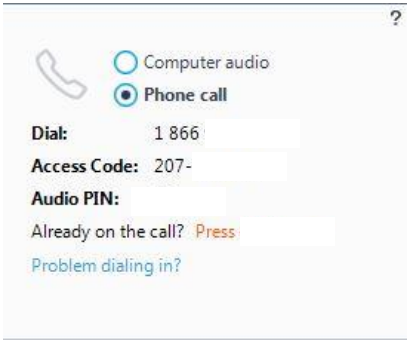

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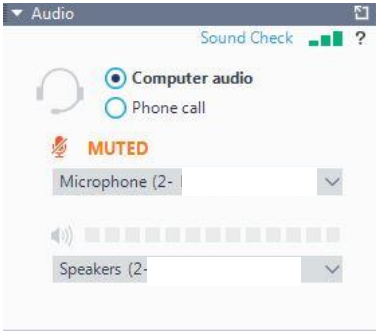

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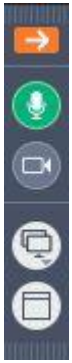

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Road Map

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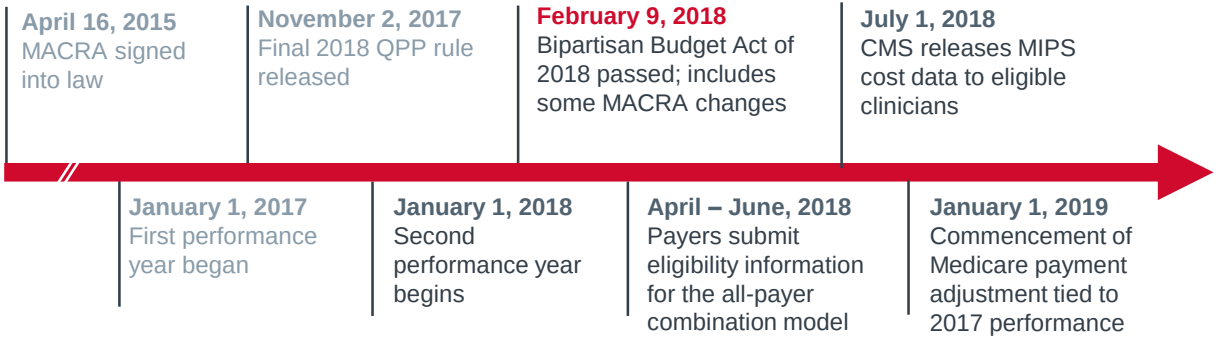
Updating the Year 2 Timeline

Majority of Providers Still Struggle with Transition to New Model

MACRA Implementation Timeline



Several Forces Drive Evolution of MACRA's Quality Payment Program

- **Lawmaking** through Congress, which may be influenced by MedPAC[1]
- **Rulemaking** through CMS in annual QPP proposal, public comment, and final rule; MACRA itself requires certain QPP changes over time
- **Sub-regulatory guidance** such as FAQs and fact sheets published by CMS to clarify and expand upon QPP policies established in the regulations

1) MedPAC = the Medicare Payment Advisory Commission, is a nonpartisan legislative branch agency that provides the U.S. Congress with analysis and policy advice on the Medicare program.

Source: CMS; Advisory Board research and analysis.

MACRA Creates CMS Quality Payment Program

CMS Quality Payment Program

Advanced Alternative Payment Models (Advanced APM)

Financial incentives: 5% annual bonus in 2019–2024, and 0.75% annual payment increase from 2026 on

Exempt from MIPS payment adjustments

Merit-Based Incentive Payment System (MIPS)

Performance based on 4 categories: Quality, Cost, IA,[1] and ACI[2]

Payment adjustments reach -9% / +27% by 2022

Included in MIPS in 2018

- Medicare Part B payments (i.e., clinician professional payments), with certain exceptions:
  - Clinicians, groups that fall under low volume threshold (i.e., $90,000 or less in Medicare charges, or 200 or fewer Medicare patients)
  - Providers in their first year billing Medicare
- Physicians, PAs,[3] NPs,[4] Clinical Nurse Specialists, Certified Registered Nurse Anesthetists,[5] and groups that include these clinicians

1) IA = Improvement Activities; 2) ACI = Advancing Care Information; 3) PAs = Physician assistants; 4) NPs = Nurse practitioners; 5) We note that additional provider types are included for APM track qualification: certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals, physical or occupational therapists, qualified speech-language pathologists, and qualified audiologists; and a group that includes these professionals.

Sources: 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," 81 FR 77008, November 4, 2016, https://www.federalregister.gov/d/2016-25240; Advisory Board research and analysis.

What's In, What's Out: 2018 QPP Final Rule

Advanced Alternative Payment Models (Advanced APM)

Merit-Based Incentive Payment System (MIPS)

Finalized Policies

- ✔ **More participants**, more Advanced APMs qualify in 2018
- ✔ **No maximum provider limit** for Round 1 CPC+[1] participants
- ✔ **All-Payer Combination** APM option details, applications open in 2018, program starts in 2019

- ✔ **Exclusions expanded**, results in more providers excluded from MIPS
- ✔ **Framework maintained**, many category requirements remain as is
- ✔ **Quality and Cost category changes**, key determinant of highest performing ECs[2]

Not Finalized For 2018

- ✖ **Different performance periods** for Medicare and all-payer APMs
- ✖ **Limitation that all-payer eligibility** can be determined only at the individual level

- ✖ **Facility-based scoring option** not finalized for 2018
- ✖ **"Mix-and-match" reporting** within a single category not finalized for 2018

Potential Future New Policies

- ? **Medicare Advantage** may help providers qualify for the APM track before 2019
- ? **New physician-focused payment models** may be proposed in the future

- ? **Part D drug costs** may be included in Cost category
- ? **Episode-based cost measures** may be introduced

1) CPC+ = Comprehensive Primary Care Plus; 2) ECs = Eligible clinicians.

Source: CMS, "Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year," November 16, 2017, https://federalregister.gov/d/2017-24067; Advisory Board research and analysis.

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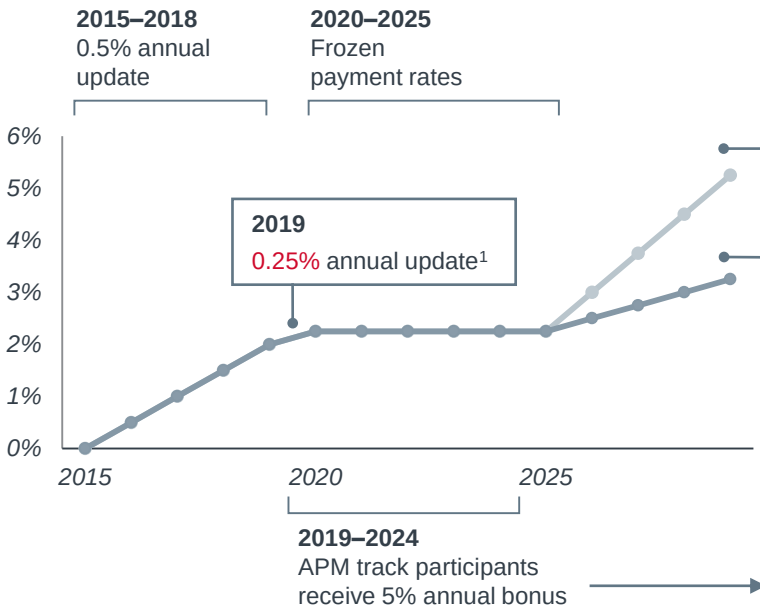
Top 5 MACRA FAQs

1. How Did the 2018 Bipartisan Budget Act Change MACRA?
2. What Are the MIPS Cost Measures?
3. Are There New MIPS Bonus Points Available in 2018?
4. What is the APM Track All Payer Combination Option?
5. How Do We Prepare for 2019?

Source: Advisory Board research and analysis.

Law Changes 2019 Baseline Payment Rate Update

Baseline Payment Rate Updates Under Each Track



Alternative Payment Model Track: 2026 and on 0.75% annual update

The Merit-Based Incentive System: 2026 and on 0.25% annual update

Annual Bonus for APM Participation

5% Bonus awarded each year from 2019–2024 to clinicians who qualify for the APM track

1) Bipartisan Budget Act of 2018 decreased 2019 baseline payment rate update from 0.50% to 0.25%.

Sources: CMS; Advisory Board research and analysis.

Two Significant Changes to MIPS

Bipartisan Budget Act of 2018

The "Transition" Years Under MIPS Expands.

Certain "transition" year policies are extended through 2021

- New Cost category weight flexibility; CMS can weigh the cost category anywhere between 10% and 30%
- Rewards for Cost category performance improvement are delayed
- Performance threshold (PT) to avoid the MIPS penalty will increase more gradually

The MIPS Payment Adjustment Scope Changes.

MIPS payment adjustments now only apply to Medicare Part B "covered professional services"

The funding law updates MACRA to no longer apply MIPS adjustments to Medicare Part B "items and services" that would otherwise have included Part B drugs

Sources: Bipartisan Budget Act of 2018; Advisory Board research and analysis.

2018 MIPS Cost Performance Category

Increases to 10% Weight in 2018; Episode Measures Yet to Be Determined

Category in Brief: Cost

- Included in 2018 MIPS final score; 10% category weight[1]
- Ramps up to 30% in 2022 performance year, as required by law[2]
- 2018 cost performance based on:
  - Total per Capita Cost
  - Medicare spending per beneficiary (MSPB)
- CMS will use data submitted through administrative claims to determine performance; no additional reporting required
- Case minimum threshold is 20 for Total per Capita Cost and Episode-Based measures; 35 for MSPB
- Eight episode-based measures currently being field tested for potential inclusion in a future year

How Scoring Works

Scoring Takeaways

- Measures are equally weighted for up to 10 achievement points each based on peer benchmark
- A measure is included in scoring only if case minimum threshold is met; total possible points can vary between ECs
- Additional improvement score up to 1% for measure-level improvement compared to prior year performance starting 2022
- 2017 cost performance will be provided to ECs for informational purposes

1) Cost category is not included in MIPS APM scoring standard.
2) Bipartisan Budget Act of 2018 allows CMS to set Cost category weight between 10% to 30% through 2021, with mandatory increase to 30% in 2022.

Source: CMS; Advisory Board research and analysis.

Understand the 2018 MIPS Cost Measures

Breaking Down Attribution, When Your Group Is Accountable

Total Cost per Capita

Definition:

Specialty-adjusted measure that evaluates overall efficiency of care. Includes all payments under Medicare Part A and B

- Must have minimum 20 cases or not scored

Attribution Method:

Two-step process

#1: Attributed to provider with largest share of primary care services provided by PCPs

#2: If beneficiary didn't visit PCP, attribution applied to specialist with plurality of services

Medicare Spending per Beneficiary

Definition:

Cost of Medicare Part A and B services during an episode defined as three days before and 30 days after inpatient hospitalization

- No longer specialty-adjusted
- Must have minimum 35 cases or not scored

Attribution Method:

Attributed to provider who provides plurality of claims for Medicare Part B Services during inpatient hospitalization[1]

Evaluate QRUR[2] cost performance

See CMS website for instructions to obtain your QRUR

1) As measured by allowable charges.
2) QRUR = Quality and Resource Use Report.

Source: CMS; Advisory Board interviews and analysis.

Maximize MIPS Performance with Bonus Points

New Types of Bonus Points Available in 2018

Quality Bonus – up to 20%

- Report[1] **additional high-priority measures** beyond one required outcome measure
  - Earn up to 10% of total possible points in the Quality category denominator
- Use **end-to-end[2] electronic reporting** to submit measures
  - Earn up to 10% of total possible points in the Quality category denominator

ACI Bonus – up to 25%

- Engage in **additional public health reporting** beyond performance score
  - Earn 5% toward 100 ACI points
- Use **CEHRT to carry out Improvement Activities**
  - Earn 10% toward 100 ACI points
- **New!** Use **2015 Edition CEHRT** exclusively and report ACI Measures
  - Earn 10% toward 100 ACI points

New! Two Types of Bonuses Applied to Composite MIPS Final Score

Small Practice – 5 points

- Practices with 15 or fewer ECs
- Group size based on number of NPIs[3] associated with a TIN, before MIPS exclusions are applied

Complex Patients – up to 5 points

- Two-component bonus based on:
  - Average HCC risk score, as indicator of medical complexity
  - Dual eligible ratio, as indicator of social risk

1) Measure must meet case minimum and data completeness requirements, and performance must be above zero. One point for each additional appropriate use, patient safety, efficiency and care coordination measure. Two points for each additional outcome and patient experience measure.
2) One point for each measure submitted using end-to-end electronic reporting. Data must be captured in CEHRT and submitted to CMS electronically, either directly or through a third-party intermediary without manual manipulation.
3) NPI = National Provider Identifier.

Source: CMS; Advisory Board research and analysis.

Forthcoming All-Payer Combination Option

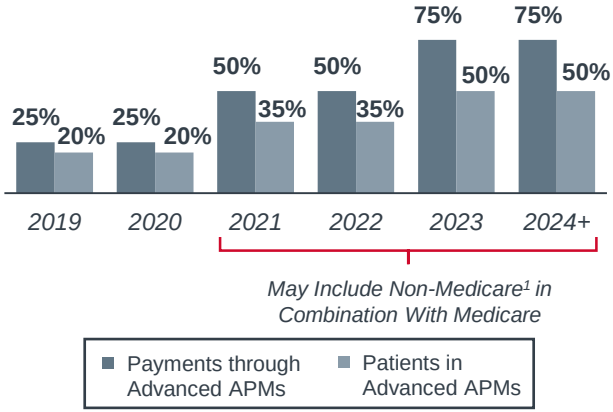
Qualifying APM Participant Thresholds Grow in Third Year and Beyond

Medicare Advanced APM Criteria

Financial Risk Criterion

- Meet revenue-based standard (average of at least 8% of revenues at risk for participating APMs) or
- Meet benchmark-based standard (maximum possible loss must be at least 3% of spending target)
- Certified EHR use
- Quality requirements comparable to MIPS

Required Payments or Patients Thresholds Per Payment Year



Engage Payers to Determine Future All-Payer Combination APM Track Eligibility

CMS aligned[2] the Advanced APM criteria under the Medicare option with the forthcoming All-Payer Combination option. Organizations should reach out to their payers in 2018 to assess the payment models that may qualify for this option in QPP Year 3.

1) In all-payer combination option, Medicare Advanced APM volume threshold (i.e., 25% payments, 20% patients) must also be met, in combination with other-payer Advanced APM volumes.
2) Add 8% revenue-based nominal amount standard for 2021 and 2022 payment years in addition to previously established 3% expenditures-based standard.

Source: CMS; Advisory Board research and analysis.

Payers Submit Advanced APM Requests in 2018

To Establish Advanced APM Status for 2019 QP Performance Period

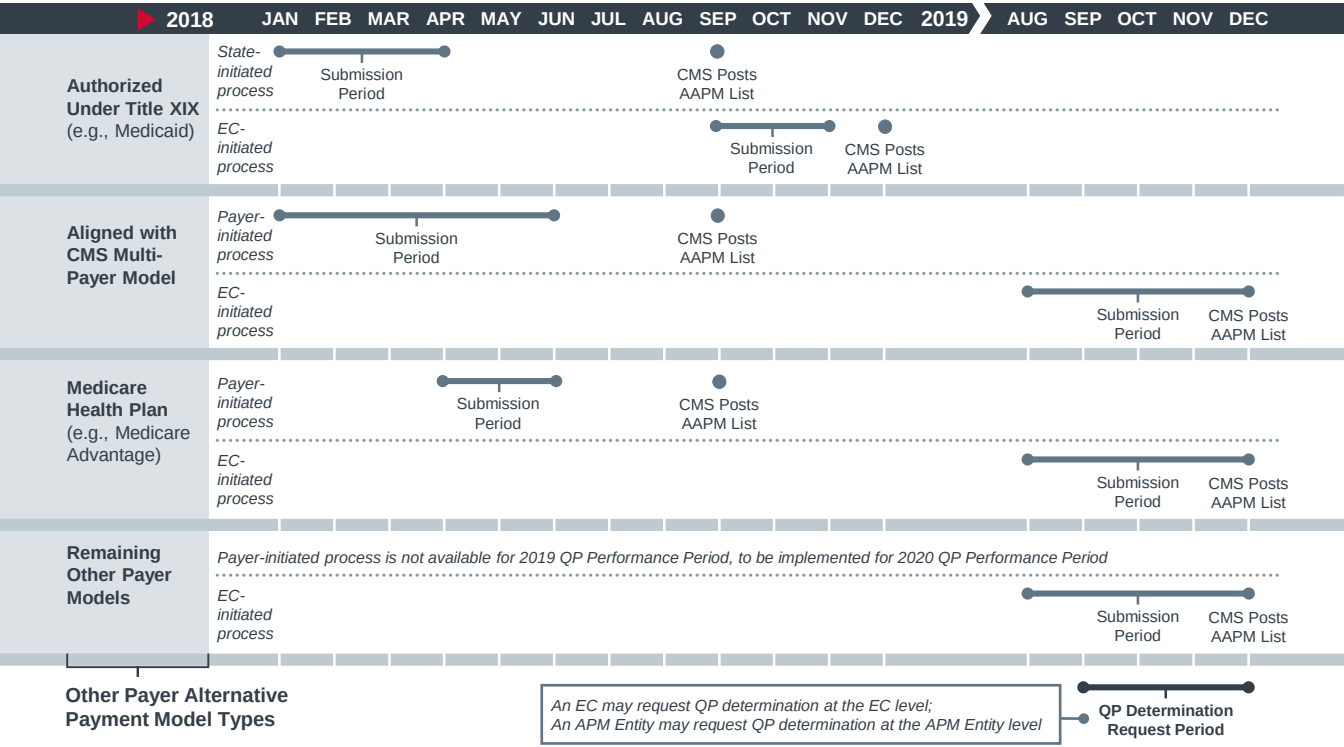
Other Payer APM Types		Payer-Initiated Process	Submission Period[1]
1	**Authorized Under Title XIX** (e.g., Medicaid)	States may submit request for both Medicaid fee-for-service and Medicaid managed care plan payment arrangements	2018 Jan 1 to Apr 1
2	**Aligned with CMS Multi-Payer Model**	Payers with payment arrangements aligned with a CMS Multi-Payer Model may submit request; In models where a state prescribes uniform payment arrangements across all payers statewide, the state would submit on behalf of payers	2018 Jan 1 to Apr 1
3	**Medicare Health Plan** (e.g., Medicare Advantage)	Payers may submit request during the same timeframe as the annual Medicare Advantage bid process	2018 Apr to June
4	**Remaining Other Payer Models**	Payers not included above, including commercial and other private payers, are **not** eligible to submit request for the 2019 QP Performance Period	

1) The deadlines are different between payer types. CMS also allows an EC-initiated process (that includes requests from APM entities), and submission periods occur later than the payer-initiated process.

Source: CMS; Advisory Board research and analysis.

Other Payer Advanced APM Determination Timeline

Process Begins in 2018 for the 2019 QP Performance Period



Source: CMS; Advisory Board research and analysis.

Stakes Legally-Mandated to Increase in Future Years

MIPS Set to Get Tougher by Law, by Design

83% Surveyed providers who reported **aware** of QPP requirements

86% Surveyed providers who reported **concerns** about implementation

4% at risk

Low performance bar, multiple reporting period options, Cost category weight at 0%

2017
QPP Year 1

5% at risk

Few changes, with most Year 1 flexibilities retained

- Year-long reporting period for Quality
- Cost category increases to 10%
- Retain Year 1 ACI measure and CEHRT requirements

2018
QPP Year 2

7% at risk

Requirements to become gradually more challenging per future rulemaking

Quality
Full-year reporting period, and potentially higher data completeness thresholds

Cost
Weight may be between 10% to 30%; improvement scoring delayed

ACI
2015 Edition CEHRT upgrade required to report Stage 3-equivalent, more difficult measures

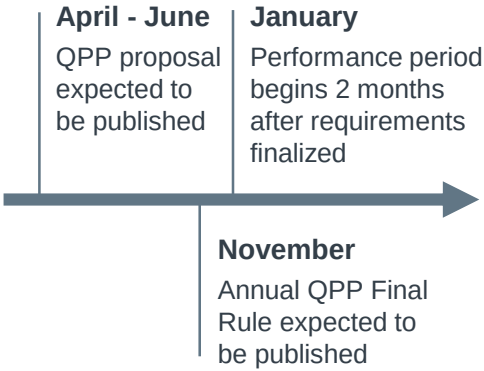
2019
QPP Year 3

Sources: CMS; "MACRA: How payers and providers can close the readiness gap," *Becker's Hospital CFO Report,* August 30, 2017, https://www.beckershospitalreview.com/finance/macra-how-payers-and-providers-can-close-the-readiness-gap.html; Advisory Board research and analysis.

Make Your Voice Heard

Set Aside Resources to Comment on Annual Changes

Annual QPP Rulemaking Timeline



Key Considerations for Future Rulemaking

- **Extreme and uncontrollable circumstances.** Support automatic penalty-exemption for affected ECs in future years
- **Other Payer APMs.** Provide feedback on whether Advanced APM determinations should apply for multiple years
- **MIPS low-volume threshold.** Comment on whether threshold should be applied at group-level, or only individual-level
- **MIPS group definition.** Suggest additional ways to define a group beyond TIN-based designation alone
- **MIPS scoring.** Recommend ways to simplify the scoring system and align policies across categories
- **Quality.** Ask for clarification on how data completeness will be assessed for all payer data
- **Facility-based ECs.** Provide feedback on notification and opt-out process for providers automatically assigned a facility-based score

Source: Advisory Board research and analysis.

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Quality Reporting Roundtable

1 **Experts On-Call**

2 **Alerts & Monitoring**

3 **Audit Support**

4 **Successful Practices**

5 **Networking**

6 **Strategic Alignment**

Areas of Expertise:

MIPS, APM, Meaningful Use, Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VBPM), Inpatient Quality Reporting Program (IQR)

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- How Northside Hospital System implements a collaborative approach among internal and external stakeholders

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