MIPS and MACRA Proposed Rule
Potential Changes for 2018 and Beyond
September 19, 2017
Agenda

- Introductions
- MIPS Recap
- MIPS Eligibility
- MIPS Scoring
  - Proposed Changes in 2018
- Scoring: Quality
- Scoring: ACI
- Scoring: IA
- Scoring: Cost
- “Bonus” Content
- APMs
- Closing Thoughts

What we won’t cover today…
- Basics of MIPS
- MIPS Scoring
- MIPS Timelines
- APM Basics
Introductions
Introductions

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MIPS Recap
QPP: Considerations from CMS

- Improve beneficiary outcomes
- Reduce burden on clinicians
- Increase adoption of Advanced APMs
- Maximize participation
- Improve data and information sharing
- Deliver IT systems capabilities that meet the needs of users
- Ensure operational excellence in program implementation

Image source: ihs.gov
Two Paths: MIPS & APMs

MACRA
Signed into law on April 16, 2015

CMS

“Quality Payment Program”
Proposed Rule published April 27, 2016
Final Rule published October 14, 2016

Two options

MIPS
(Merit-Based Incentive Payment System)

APMs
(Alternative Payment Models)

AAPMs
(Advanced Alternative Payment Models)
Components of MIPS

MIPS ties a portion of Medicare Part B reimbursement to a clinician’s *performance* across four distinct categories:

- **Quality**
- **Advancing Care Information**
- **Improvement Activities**
- **Cost**

**MIPS Final Score**

(0 – 100)
# MIPS Performance Categories and Scoring

## Shift from Quality to Cost

### MIPS Year 1
- **Quality**: 60%
- **Advancing Care Information (i.e. MU)**: 25%
- **Improvement Activities**: 15%

### MIPS Year 2
- **Quality**: 50%
- **Advancing Care Information (i.e. MU)**: 25%
- **Improvement Activities**: 15%
- **Cost**: 10%

*Cost proposed at 0% for 2018*

### MIPS Year 3
- **Quality**: 30%
- **Advancing Care Information (i.e. MU)**: 30%
- **Improvement Activities**: 15%
- **Cost**: 30%

### 2017 Performance Year
- **2018 Performance Year**
- **2019 Performance Year**
MIPS Performance Categories and Scoring

Shift from Quality to Cost

MIPS Year 1
- Quality: 25%
- Advancing Care Information (i.e. MU): 15%
- Improvement Activities: 60%

MIPS Year 2
- Quality: 25%
- Advancing Care Information (i.e. MU): 15%
- Improvement Activities: 60%

MIPS Year 3
- Quality: 25%
- Advancing Care Information (i.e. MU): 15%
- Improvement Activities: 30%
- Cost: 30%

2017 Performance Year
2018 Performance Year
2019 Performance Year
MIPS Eligibility
Eligibility Thresholds Reduced

• Proposed for 2018 is an easing of the low-volume threshold for MIPS exclusion for individuals or groups:
  – Bill <= $90,000 in Medicare Part B
  – Care for <= 200 Medicare Part B enrolled beneficiaries
  – Current rule is $30,000 / 100 patients

• Eligible Clinicians under the thresholds can still “opt-in” if they choose
  – May encourage high performers to participate in MIPS
  – For 2018, voluntary participants (groups or individuals) would not be subject to MIPS payment adjustments
  – For 2019, voluntary participants (groups or individuals, and who exceed one of the low-volume thresholds) would be subject to MIPS payment adjustments

• How could this impact MIPS/MACRA going forward?
Fewer small clinicians are eligible

Larger groups migrate to APMs

Clinician Performance

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Fewer small clinicians are eligible

Increased competition for Eligible Clinicians involved in MIPS

Larger groups migrate to APMs

Required to Be Budget Neutral
Virtual Groups

• Proposed to be available in 2018
• Two (or more) TINs
  – Solo practitioner (no other NPIs billing under the TIN)
  – Group with 10 or fewer Eligible Clinicians
    • All Eligible Clinicians in a group must participate in the virtual group
• Virtual groups are in place for a performance period of 1 year
• Must elect to participate as a virtual group prior to the beginning of the performance period
  – Cannot “drop out” once the performance period begins
  – If TINs/NPIs move to APMs, CMS will use waiver authority use the APM score instead of the virtual group score
• How could this impact MIPS/MACRA going forward?
Virtual Groups – Other Considerations

- Generally policies that apply to groups apply to virtual groups
  - Exceptions:
    - Non-patient facing clinicians
    - Small practice, rural area and HPSA designations
- Virtual groups use the same submission mechanisms as groups
- There are no restrictions to group composition based on geographic area or specialty
- As proposed, there will be no restrictions on overall group size (at least for 2018)
- CMS will offer a “Model Agreement” template for virtual groups to consider using
MIPS Scoring

Proposed Changes to MIPS Scoring in 2018
Performance Thresholds

- Each year, CMS will set a “MIPS Performance Threshold”
- If ECs are above the threshold, they are guaranteed to receive a neutral or positive payment adjustment
- Additional incentives for “Exceptional Performance”

100 Points Total in MIPS Composite Score

$199 Million

$500 Million
Exceptional Performance

- $199 M

3
2017 Performance Threshold

15
2018 Performance Threshold [proposed]

70
2017 and 2018 Exceptional Performance Threshold
# MIPS Scoring Details in 2017 and 2018

<table>
<thead>
<tr>
<th>Final Score (Transition Year)</th>
<th>Transition Year Payment Adjustment</th>
<th>Final Score (Year 2)</th>
<th>Year 2 Proposed Payment Adjustment</th>
</tr>
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<tbody>
<tr>
<td>≥70 points</td>
<td>Positive adjustment</td>
<td>≥70 points</td>
<td>Positive adjustment</td>
</tr>
<tr>
<td></td>
<td>Eligible for exceptional performance bonus—minimum of additional 0.5%</td>
<td></td>
<td>Eligible for exceptional performance bonus—minimum of additional 0.5%</td>
</tr>
<tr>
<td>4-69 points</td>
<td>Positive adjustment</td>
<td>16-69 points</td>
<td>Positive adjustment</td>
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<tr>
<td></td>
<td>Not eligible for exceptional performance bonus</td>
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<td>Not eligible for exceptional performance bonus</td>
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<tr>
<td>3 points</td>
<td>Neutral payment adjustment</td>
<td>15 points</td>
<td>Neutral payment adjustment</td>
</tr>
<tr>
<td>0 points</td>
<td>Negative payment adjustment of -4%</td>
<td>0 points</td>
<td>Negative payment adjustment of -5%</td>
</tr>
<tr>
<td></td>
<td>0 points = does not participate</td>
<td></td>
<td>0 points = does not participate</td>
</tr>
</tbody>
</table>

How Is Data Submitted to CMS?

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Submission Mechanisms for Individuals</th>
<th>Submission Mechanisms for Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Claims, QCDR, Qualified registry, EHR</td>
<td>QCDR, Qualified registry EHR, CMS Web Interface (groups of 25 or more)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMS-approved survey vendor for CAHPS for MIPS (must be reported in conjunction with another data submission mechanism.) Administrative claims (for readmission measure – no submission required)</td>
</tr>
<tr>
<td>Cost</td>
<td>Administrative claims (no submission required)</td>
<td>Administrative claims (no submission required)</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>Attestation, QCDR, Qualified registry, EHR</td>
<td>Attestation, QCDR, Qualified registry, EHR, CMS Web Interface (groups of 25 or more)</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>Attestation, QCDR, Qualified registry, EHR</td>
<td>Attestation, QCDR, Qualified registry, EHR, CMS Web Interface (groups of 25 or more)</td>
</tr>
</tbody>
</table>

Only one submission mechanism allowed for each performance category in 2017. In 2018, CMS is proposing to allow multiple mechanisms per category.

Scoring: Quality
Proposed Quality Changes for 2018

- Increase the data completeness threshold to 60% for the 2019 MIPS performance period
  - Measures that fail data completeness will receive 1 point (instead of 3 points)
    - Small practices will continue to receive 3 points
- Maintain 3 point floor for measures scored against a benchmark
- Maintain 3 points for measures that do not have a benchmark or do not meet the case minimum.
- No change to existing Quality bonuses
- Proposed changes to CAHPS survey collection and scoring
- Topped out measures
  - Cap of 6 points applied for 6 topped out measures
  - Potential to eliminate topped out measures after 3 years
  - Will not apply to CMS web interface measures
Scoring Improvements

• Rewards clinicians (individuals or groups) who demonstrate improved scores compared to the prior performance period

• For quality:
  – Improvement scoring will be based on the rate of improvement
    • For those who have not previously performed well higher improvement will result in more points
  – Improvement is measured at the performance category level.
  – Up to 10 percentage points available in the performance category.
    • In 2020, improvement percentage points will be added to the quality performance category
    • Performance category scores cannot exceed 100%
ACI in the 2018 Proposed Rule

- No changes to ACI objectives or measures proposed
- New flexibility in public health objective for ECs who cannot meet Immunization Registry Reporting measure
- More improvement activities available in ACI bonus category
- 2015 Edition CEHRT not *required* until 2019 performance year
- Additional **10 point bonus** for ECs who use *only* 2015 Edition CEHRT in 2018

**Base Score**

50 points

**Performance Score**

Between 0 and 90 points

**Bonus Points**

Maximum of **25 points proposed**

(up from 15 points in 2017)

*ACI score still cannot exceed 100 points*
ACI in the 2018 Proposed Rule (cont.)

Delaying the 2015 Edition CEHRT requirement until 2019 would mean ECs have two options in 2018 (same as 2017)

- **Report on the *Standard Set* of ACI Measures**
  - Based on MU Stage 3 objectives and measures
    - 5 “base” measures; 13 measures in total
    - 2015 Edition CEHRT only

- **Report on the “Transition” Set of ACI Measures**
  - Based on Modified Stage 2 objectives and measures
    - 4 “base” measures; 11 measures in total
# Standard Set of ACI Measures (2015 Edition CEHRT)

<table>
<thead>
<tr>
<th>Objective / Measure</th>
<th>Required for Base Score?</th>
<th>Possible Performance Score Points</th>
<th>Bonus Points</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security Risk Analysis</td>
<td>✓</td>
<td>--</td>
<td>--</td>
<td>Y / N</td>
</tr>
<tr>
<td>E-Prescribing</td>
<td>✓</td>
<td>--</td>
<td>--</td>
<td>Num / Denom</td>
</tr>
<tr>
<td>Patient Electronic Access</td>
<td>✓</td>
<td>0 – 10</td>
<td>--</td>
<td>Num / Denom</td>
</tr>
<tr>
<td>Patient-Specific Education</td>
<td>--</td>
<td>0 – 10</td>
<td>--</td>
<td>Num / Denom</td>
</tr>
<tr>
<td>View, Download, Transmit (VDT)</td>
<td>--</td>
<td>0 – 10</td>
<td>--</td>
<td>Num / Denom</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>--</td>
<td>0 – 10</td>
<td>--</td>
<td>Num / Denom</td>
</tr>
<tr>
<td>Patient-Generated Health Data</td>
<td>--</td>
<td>0 – 10</td>
<td>--</td>
<td>Num / Denom</td>
</tr>
<tr>
<td>Send Summary of Care</td>
<td>✓</td>
<td>0 – 10</td>
<td>--</td>
<td>Num / Denom</td>
</tr>
<tr>
<td>Request/Accept Summary of Care</td>
<td>✓</td>
<td>0 – 10</td>
<td>--</td>
<td>Num / Denom</td>
</tr>
<tr>
<td>Clinical Information Reconciliation</td>
<td>--</td>
<td>0 – 10</td>
<td>--</td>
<td>Num / Denom</td>
</tr>
<tr>
<td>Immunization Registry Reporting</td>
<td>--</td>
<td>0 or 10</td>
<td>--</td>
<td>Y / N</td>
</tr>
<tr>
<td>Additional Public Health Registries</td>
<td>--</td>
<td>5 or 10*</td>
<td>5</td>
<td>Y / N</td>
</tr>
<tr>
<td>Report Improvement Activities</td>
<td>--</td>
<td>--</td>
<td>10</td>
<td>Y / N</td>
</tr>
<tr>
<td>Report using <em>only</em> 2015 CEHRT</td>
<td>--</td>
<td>--</td>
<td>10</td>
<td>--</td>
</tr>
</tbody>
</table>

*Available as part of the performance score for ECs who cannot meet the Immunization Registry Reporting measure. To qualify for public health reporting bonus, the EC must report to a different public health registry than the registry used to earn points towards the performance score.
## “Transition” Set of Measures (2014 Edition CEHRT)

<table>
<thead>
<tr>
<th>Objective / Measure</th>
<th>Required for Base Score?</th>
<th>Possible Performance Score Points</th>
<th>Bonus Points</th>
<th>Type</th>
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<td>Security Risk Analysis</td>
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<td>✓</td>
<td>--</td>
<td>--</td>
<td>Num / Denom</td>
</tr>
<tr>
<td>Patient Electronic Access</td>
<td>✓</td>
<td>0 – 20</td>
<td>--</td>
<td>Num / Denom</td>
</tr>
<tr>
<td>Patient-Specific Education</td>
<td>--</td>
<td>0 – 10</td>
<td>--</td>
<td>Num / Denom</td>
</tr>
<tr>
<td>View, Download, Transmit (VDT)</td>
<td>--</td>
<td>0 – 10</td>
<td>--</td>
<td>Num / Denom</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>--</td>
<td>0 – 10</td>
<td>--</td>
<td>Num / Denom</td>
</tr>
<tr>
<td>Send Summary of Care (&quot;HIE&quot;)</td>
<td>✓</td>
<td>0 – 20</td>
<td>--</td>
<td>Num / Denom</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>--</td>
<td>0 – 10</td>
<td>--</td>
<td>Num / Denom</td>
</tr>
<tr>
<td>Immunization Registry Reporting</td>
<td>--</td>
<td>0 or 10</td>
<td>--</td>
<td>Y / N</td>
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<tr>
<td>Additional Public Health Registries</td>
<td>--</td>
<td>5 or 10*</td>
<td>5</td>
<td>Y / N</td>
</tr>
<tr>
<td>Report Improvement Activities</td>
<td>--</td>
<td>--</td>
<td>10</td>
<td>Y / N</td>
</tr>
</tbody>
</table>

*Available as part of the performance score for ECs who cannot meet the Immunization Registry Reporting measure. To qualify for public health reporting bonus, the EC must report to a different public health registry than the registry used to earn points towards the performance score.
Scoring: IA

*Improvement Activities*
Improvements Activities

- Minimal changes proposed for 2018
- 15% of composite score
- Minimum 90-day performance period
- Total of 40 points for full credit
  - Divided into “High Weighted” and “Medium Weighted” measures
  - High Weighted measures 20 points each
  - Medium Weighted measures 10 points each
- Small practice and rural areas – 20 points for full credit
- PCMH automatically receives full IA credit
- Groups and virtual groups – only 1 participant in TIN required to do an activity for credit
- Simple attestation method
Improvement Activities for Medical Home Models

- 2017 – only one practice in TIN needs to be a PCMH to receive full IA credit
- Proposed 2018 – minimum 50% of practices in TIN need to be PCMH to receive full IA credit
- CPC+ APM proposed to get full IA credit in 2018
Inventory of Improvement Activities

- Proposing new/additional Improvement Activities for 2018
- Some 2017 Improvement Activities may be removed from list of eligible activities
- Looking to add more activities that show use of CEHRT – qualify for 10% ACI Bonus
- Adding at least one new Appropriate Use Criteria activity
Scoring: Cost
Cost Category

- 2018 delaying the requirement to participate in cost category
- 2019 cost will be 30% of composite score
- Rewards improvements in performance compared to prior years performance
- Providers should continue to prioritize cost control efforts
- Allow hospital-based clinicians to submit their facility's inpatient value-based purchasing score to be used to calculate an individual score for the cost and quality categories of MIPS
  - Hospital Total Performance Score = MIPS Quality and Cost Performance
“Bonus” Content
Complex Patient Bonus

• New for 2018 MIPS
• Based on complexity of patient populations
• Eligible Clinicians and groups can earn up to 3 bonus points
  – Generally between 1 and 3 points added to composite score
  – Not performance category specific
• Propose using Hierarchical Condition Category (HCC) score to determine complexity of patient population
Small Practice Bonus

• New for 2018
• Clinicians in a small practice (15 or fewer clinicians)
  – Individuals or Groups
  – Must submit data on at least 1 performance category
  – Add 5 additional points to the final score
• May be extended to practices in rural areas as well in final rule
Facility Based Measurement

- Voluntary (opt-in)
- Aligned with VBP (Value-Based Purchasing)
- Available for quality and cost performance categories
  - Converts a hospital “Total Performance Score” into MIPS Quality and Cost performance scores
- Individuals:
  - 75% of services in inpatient hospital or emergency room
- Group:
  - 75% of eligible clinicians must be requirements as individuals
- Scores derived from the facility where the clinician treats the highest number of Medicare beneficiaries
Non Patient-Facing Clinicians

• Clinicians with <= 100 patient-facing encounters
• Groups:
  – >75% of NPIs billing under the group TIN during a performance period are non-patient facing
• Virtual Groups
  – >75% of NPIs within a virtual group during a performance period are non-patient facing
• If non-patient-facing, two performance categories are adjusted:
  – Improvement Activities
    • Fewer activities need to be reported (2 medium or 1 high)
  – Advancing Care Information
    • Performance category weight set to zero
    • Points reallocated to other performance categories
APMs
Alternative Payment Models (APMs)

Non-FFS Payment Models

“Alternative Payment Models” (APMs)

Advanced APMs
Overview: Why Are Advanced APMs Important?

- “Qualifying Participants” (QPs) in Advanced APMs during a given performance period will:
  - Be exempt from MIPS for the corresponding payment year; and
  - Receive an additional 5% bonus
- “Qualifying participation” determined by either:
  - The percent of patients seen through Advanced APMs; or
  - The percent of payments received through Advanced APMs
- There are two distinct types of Advanced APMs:
  - “Medicare Option” – Medicare Advanced APMs only
  - “All Payer Option” – Advanced APMs from Medicare and those from State Medicaid programs, commercial payers, etc.

The 2018 Proposed Rule begins to flesh out how the “All Payer Option” will work in practice
Advanced APMs: The “All Payer Option”

- Under the “All Payer Option,” QP determination would be done at the individual EC level only
- Potential to be very confusing and cumbersome in practice
  - Payer-initiated vs. EC-initiated process to determine if APM meets criteria
  - Deadlines and mechanics for APM determination vary by payer type
    - Medicaid vs. Medicare Advantage vs. “CMS Multi-Payer Models”
    - Advanced APMs from most commercial payers essentially delayed until 2020 performance period

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>All Payer Option</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Medicaid, Medicare Advantage, and “CMS Multi-Payer Models” only
Other Notes on APMs from the Proposed Rule

• CMS estimates the number of Medicare clinicians qualifying as part of an Advanced APM will double to 180,000 to 245,000.
  – Inclusion of new Medicare Track 1+ program
  – Reopening of applications for the Next Generation ACO program
  – Reopening of applications for the Comprehensive Primary Care Plus (CPC+) program

• No change to APM qualification criteria
  – Maintain existing QP determination criteria for 2018, 2019 and 2020
  – Risk-based programs eligible for the APM track would still require a revenue-based nominal amount standard at 8% of the estimated average total Parts A and B revenue of eligible clinicians.
  – Medicare Shared Savings Program Track 1 – NOT and Advanced APM
## Medical Home Model

<table>
<thead>
<tr>
<th>2017 Final Rule</th>
<th>Proposed 2018 Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total potential risk for an APM entity must be equal to at least:</strong></td>
<td><strong>Total potential risk for an APM entity must be equal to at least:</strong></td>
</tr>
<tr>
<td><strong>2017 performance year</strong> = 2.5% of the estimated average total Part A and B revenue of participating APM entities</td>
<td><strong>2018 performance year</strong> = 2% of the estimated average total Part A and B revenue of participating APM entities</td>
</tr>
<tr>
<td><strong>2018 performance year</strong> = 3% of the estimated average total Part A and B revenue of participating APM entities</td>
<td><strong>2019 performance year</strong> = 3% of the estimated average total Part A and B revenue of participating APM entities</td>
</tr>
<tr>
<td><strong>2019 performance year</strong> = 4% of the estimated average total Part A and B revenue of participating APM entities</td>
<td><strong>2020 performance year</strong> = 4% of the estimated average total Part A and B revenue of participating APM entities</td>
</tr>
<tr>
<td><strong>2020 performance year</strong> = 5% of the estimated average total Part A and B revenue of participating APM entities</td>
<td><strong>2021 performance year</strong> = 5% of the estimated average total Part A and B revenue of participating APM entities</td>
</tr>
</tbody>
</table>
Closing Thoughts
Closing Thoughts

• Two of CMS’ primary goals for the proposed changes in 2018 are to reduce the burden on ECs and to drive participation in Advanced APMs
  – Actual impact *in practice* very much remains to be seen

• The 2018 Proposed Rule represents mostly *minor* tweaks; Congressional action required for any major QPP changes
  – Budget neutrality, scaling factor, MIPS performance categories, Advanced APM definition, etc. are all “hard coded” in the MACRA legislation

• Expect CMS to continue to “tinker” with certain details each year based on actual experience and public comments
Closing Thoughts

• The sheer complexity of the QPP continues to pose a significant challenge
  – It seems as if there are an increasing number of caveats / nuances that are specific to a given provider or organization
  – Is the QPP starting to feel like an example of “personalized regulation”?
• 2018 is intended to be the last “transition year”
  – In 2019, cost category set to increase from 0% to 30%, MIPS Performance Threshold based on the mean or median score of all participants
• Important to monitor the proposed and final rule on QPP requirements each year
  – Other CMS rules moving forward may also have an impact on the QPP
    • e.g., new CEHRT requirements from ONC; rules or guidance specific to an APM
Top 5 Things to Do Right Now

• “Party like it’s 2019”
  – Don’t be lulled into a false sense of security by the “transition years”
• Moving forward for new ECs, understand impact of previous performance under MU or QPP
  – “Inherited liability” and impact on recruiting, credentialing, contracting, etc.
• Understand how the rules / requirements affect your organization
  – Many caveats and nuances; don’t hesitate to reach out to CMS directly to get clarification on specific scenarios or unique circumstances
• Actively participate in the annual QPP rulemaking process by submitting public comments to CMS
• Make sure your organization has a complete QPP structure in place
  – Are your quality and IT departments having regular QPP conversations?
Lingering Thoughts

• Will the proposed changes actually result in a reduced regulatory burden?
• Do the proposed changes make things more confusing?
• Will the proposed changes result in more participation in Advanced APMs?
• How will the proposed changes impact the “MIPS competition curve”?
• Will virtual groups allow practices to remain independent?
• Will MIPS score transparency impact providers’ reputations and ability to contract with health plans?
• Will providers (and groups) understand their scoring – and how to improve it?
• Will providers (and groups) be able to fully understand their rates of reimbursement from CMS in future years?
• Will the QPP result in better care, at lower costs?
Questions / Discussion