


Welcome to “Macra Part II: A Practical Approach”

- We will begin the seminar at 12:10 p.m. ET
- No cameras today
- Please mute your audio
- Virtual Seminar archive: <http://myHCDS.Dartmouth.edu>
- **CME/CNE Credit:** <http://dartgo.org/cme-cne>
-  [#mhcdsLive](https://twitter.com/mhcdsLive)
- **Upcoming events:**
 - Learning Expedition: UHC Innovation Center, Oct. 13-15
 - IHI mini-reunion, Dec. 4-7
 - 2017 Symposium, Apr. 6-7, 2017



Macra Part II: A Practical Approach

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MACRA Part II: A Practical Approach

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The views expressed herein are those of the presenter only and do not reflect the views of the federal government.



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Disclosures

- I have no personal or professional financial relationship or interest with any proprietary entity producing healthcare goods/or services.
- I currently serve as a consultant for the U.S. Department of Health and Human Services.



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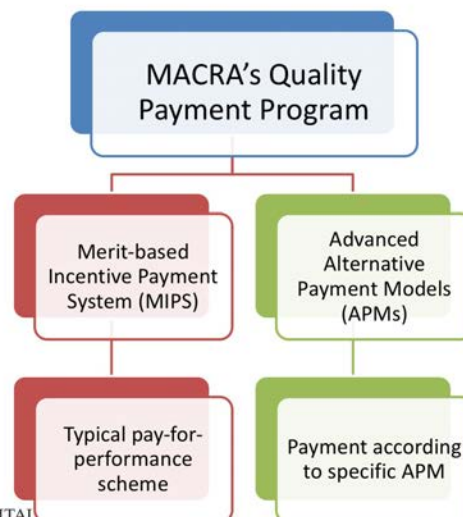
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MACRA

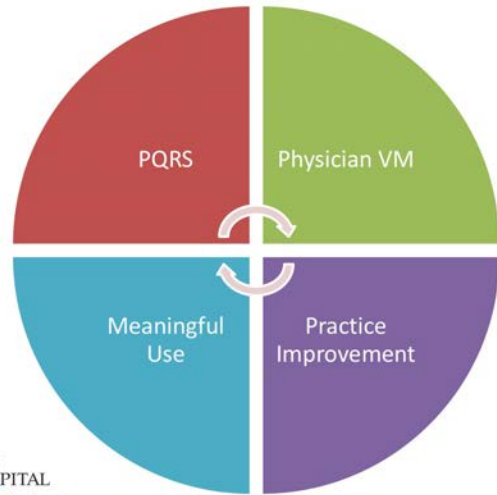
- Medicare Access and CHIP Reauthorization Act – April 2015
- Replaced SGR formula with automatic annual increases in physician payments through 2019
- Starting in 2019, automatic increases end and the Merit-Based Payment Incentive System (MIPS) begins



MACRA created two tracks

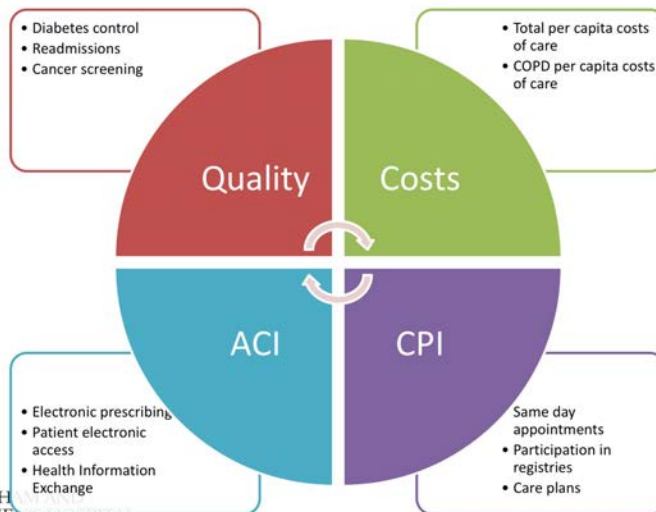


MIPS combines three old programs and adds a fourth component



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Weighting changes over time

MIPS Score, 2019



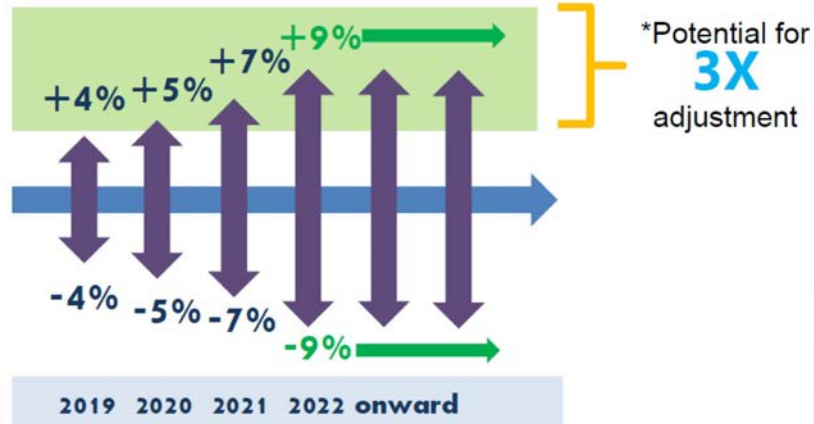
MIPS Score, 2021



MIPS payment basics

- Significant dollars at risk:
 - Penalties of -4% in 2019 up to - 9% by 2022
 - Lowest quartile performance score providers receive maximum penalty
- Budget neutral:
 - Every participating physician receives an upward or downward payment
 - Scaling factor for budget neutrality (up to 3) means maximum incentive could be 12% in 2019
- Extra bonus for exceptional performance
 - Additional \$5 million/year, up to 10%, 2019-2024

MIPS payment over time



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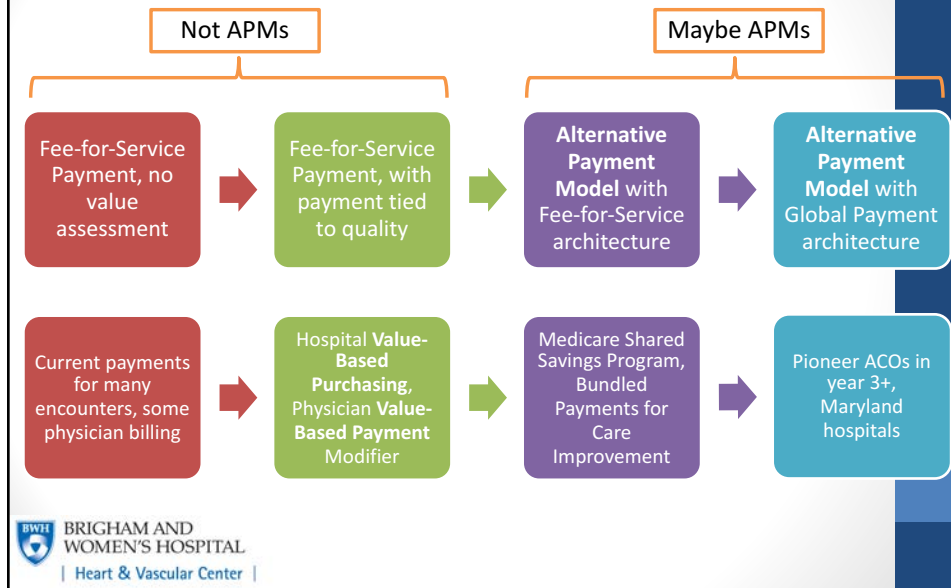
Exemptions from MIPS

New Providers	Low-Volume Providers	Advanced Alternative Payment Models
<ul style="list-style-type: none"> • First year of Medicare billing 	<ul style="list-style-type: none"> • <\$10,000 in Medicare charges and <100 Medicare patients 	<ul style="list-style-type: none"> • Adequate volume of cases in a qualifying APM

Note: MIPS includes Physicians, PAs, NPs, Clinical nurse specialists, and Certified registered nurse anesthetists in years 1 and 2; Secretary may broaden to include more clinicians in year 3+ (Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals)

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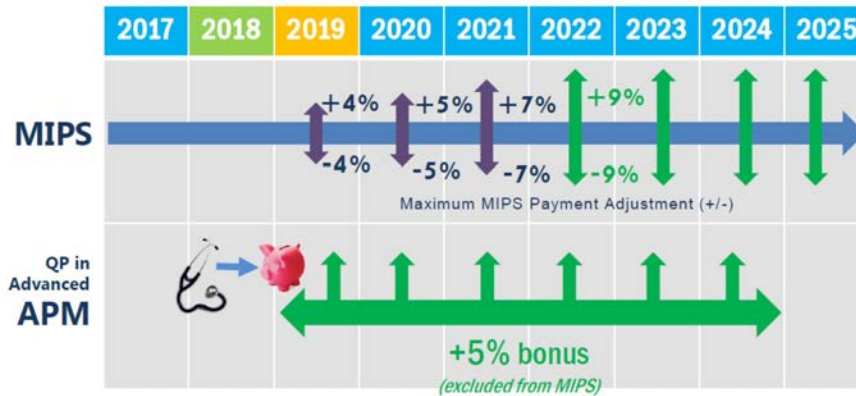
What are APMs?



The APM payment track

- “Qualifying APM participants” (QPs), won’t be subject to MIPS – instead will receive a 5% lump sum incentive payment

Financial implications of choice



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2 Steps to being a QP

Join an Advanced APM

- 1) "Recognized" as an APM: CMMI model, Medicare Shared Savings Program, demonstration under Health Care Quality Demo, demonstration required under Federal Law
- 2) Requires participants to use EHR technology;
- 3) Bases payment on quality measures that are comparable to MIPS; and
- 4) Has financial risk for monetary losses in excess of a nominal amount OR is a medical home

Have adequate \$ or patients under the APM

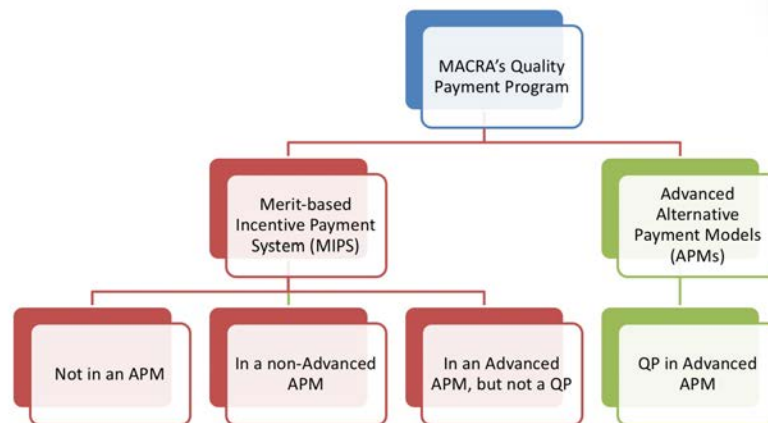
- 25% of \$ or 20% of patients in 2019
- 75% of \$ or 50% of patients in 2024 and beyond

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Examples of Advanced APMs

- MSSP – only tracks 2 and 3
- Next Generation ACO Model
- Comprehensive ESRD Care (CEC)
- Comprehensive Primary Care Plus (CPC+)
- Oncology Care Model (2-sided risk track)

Most clinicians will be in MIPS

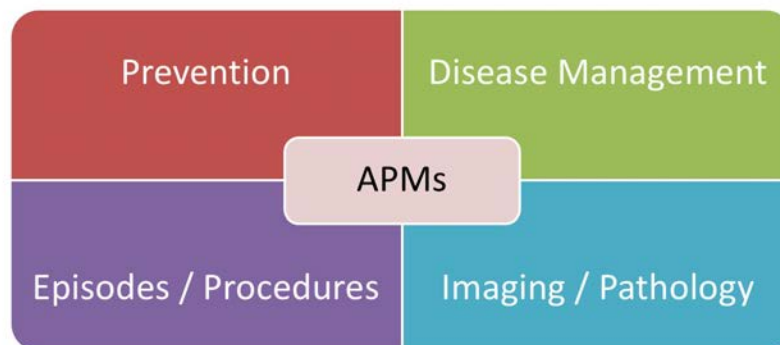


- Providers in “non-Advanced” APMs are in MIPS
- Providers in Advanced APMs but without adequate \$/patients are “partial qualifiers” and can opt out of MIPS

What might drive the choice?

- Knowledge of own performance
- Availability of an APM
- Applicability of an APM
- Financial risk under an APM

Development of new APMs



- Physician Focused Payment Models (PFPMs) Technical Committee
 - Eleven members, physicians and non-physicians
 - Charged with establishing criteria for payment models and making recommendations on moving them forward

Phase-In: 2017 (for 2019 \$)

Option 1

Submit
SOME data
→ no
payment
adjustment

Option 2

Submit
MORE data
→ chance
for small
positive
payment
adjustment

Option 3

Submit **ALL**
data
→ chance
for full
positive
payment
adjustment

Option 4

Join an
**Advanced
APM**
→ 5%
bonus, no
downside
risk

Summary

- MACRA repealed the SGR and left something more confusing in its place
- MIPS: value-based payment model
- APMs: alternative payment models
- The choice is meaningful and has financial implications



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Thank You

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References

- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program.html>
- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MACRA-NPRM-slides-short-version.pdf>
- <https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>



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Appendix slides

Measures


- Quality domain:
 - Must submit 6 measures (from 9 in PQRS)
 - One must be an outcome measure and one must be a “cross-cutting” measure
- Resource Use domain:
 - Automatically calculated, for all applicable measures
 - Adding 40+ episode measures (from 6 in PQRS)

Measures

- Clinical Practice Improvement
 - 90+ “activities” – must select at least one
 - Full credit for PCMH, half-credit for any APM

- Advancing Clinical Information
 - 6 mandatory measures (“base” measures), reporting only (50 points)
 - “Performance measures” selected from list (80 points)
 - Score > 100 receives full credit

Calculating Performance Score

Category	Weight	Scoring
 Quality	50%	<ul style="list-style-type: none"> • Each measure 1-10 points compared to historical benchmark (if avail.) • 0 points for a measure that is not reported • Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR reporting • Measures are averaged to get a score for the category
 Advancing care information	25%	<ul style="list-style-type: none"> • Base score of 50 points is achieved by reporting at least one use case for each available measure • Up to 10 additional performance points available per measure • Total cap of 100 percentage points available
 CPIA	15%	<ul style="list-style-type: none"> • Each activity worth 10 points; double weight for “high” value activities; sum of activity points compared to a target
 Resource Use	10%	<ul style="list-style-type: none"> • Similar to quality

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