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# MACRA RFI Feedback Webinar

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Lead

October 21, 2015

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Association of
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# Important Info on MACRA Request For Information (RFI)

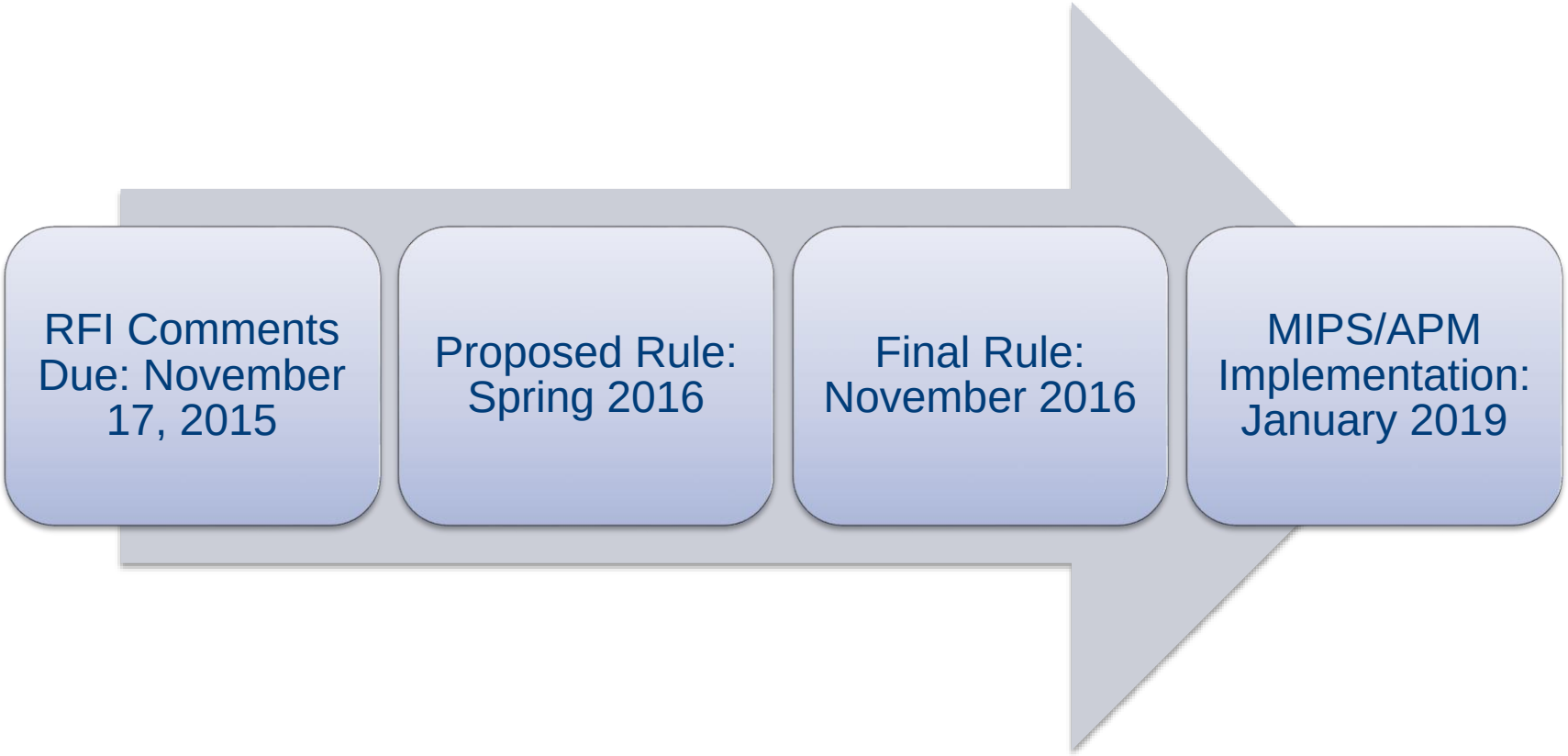
**Announcement in *Federal Register***:
http://www.gpo.gov/fdsys/pkg/FR-2015-10-01/pdf/2015-24906.pdf

**Announcement of 15 Day Extension**:
https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-26568.pdf

**Comments Due**: November 17, 2015

**Additional Information will be posted here**:
https://www.aamc.org/initiatives/patientcare/patientcarequality/311244/physicianpaymentandquality.html

# Updated Regulatory Timeline



# Overview of MACRA

- Signed into law 4/15/2015
- Repeals 1997 Sustainable Growth Rate (SGR) Physician Fee Schedule (PFS) Update
- Changes Medicare FFS PFS Payment to
  - Merit-Based Incentive Payment System (MIPS) OR
  - Incentive for participation in an Alternative Payment Model (APM)

# MACRA Transition Timeline

<table>
<tr><th></th><th>Jul-Dec 2015</th><th>2016</th><th>2017</th><th>2018</th><th>2019</th><th>2020</th><th>2021</th><th>2022</th><th>2023</th><th>2024</th><th>2025</th><th>2026 and beyond</th></tr>
<tr><td>Annual Updates</td><td colspan="5">+0.5%</td><td colspan="6">+0.0%</td><td>2 Options:<br>Qualifying APM: +0.75%<br>Other: +0.25%</td></tr>
<tr><td>PQRS Penalty</td><td colspan="4">2%</td><td colspan="8" rowspan="3">Penalties transition to MIPS; $500M pool for additional incentives</td></tr>
<tr><td>Medicare EHR Penalties</td><td>1% or 2%</td><td>2%</td><td>3%</td><td>3% or 4%</td></tr>
<tr><td>VM Max Penalty*</td><td>Up to 1%</td><td>Up to 2%</td><td>Up to 4%</td><td>TBD</td></tr>
<tr><td colspan="5">Merit-Based Incentive Program System (MIPS)*<br>(Only max reduction listed; incentives available, see notes)</td><td>4% at risk</td><td>5% at risk</td><td>7% at risk</td><td colspan="3">9% at risk</td><td>+0.25% update + (9%) at risk</td></tr>
<tr><td colspan="11">Exclusions from MIPS</td><td></td></tr>
<tr><td colspan="5">Qualifying APM Participant (QP)</td><td colspan="5">Bonus: 5% lump sum payment<br>(based on services in preceding year); No MIPS risk</td><td>No Bonus; No MIPS risk</td><td>+0.75% update; No MIPS risk</td></tr>
<tr><td colspan="5">Other MIPS Exclusions<br>(Low volume; Partial Qualifying APM w/ no MIPS reporting)</td><td colspan="5">No Bonus, No MIPS risk</td><td>+0.25% update; No MIPS risk</td></tr>
</table>

* VM and MIPS have possible upward or downward adjustments. Due to budget neutrality, incentives scale based on available funds. Maximum reduction for MIPS listed in statute.

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# Merit-Based Incentive Payment System (MIPS)

# Overview of MIPS

- Separate application of payment adjustments under PQRS, VM, and EHR-MU will sunset Dec. 31, 2018 and MIPS payment adjustment begins on Jan 1, 2019
- Under MIPS the Secretary must develop a methodology to assess EP performance and determine a composite performance score and is currently seeking feedback through the RFI.  There can be group reporting.
- Features of PQRS, the Value Modifier and the EHR Meaningful Use program are included in MIPS
- The score is used to determine and apply a MIPS payment adjustment factor for 2019 onward
- Adjustment Can Be Positive, Negative, or Zero

# MIPS Composite Performance Score

**Performance threshold will be established based on the mean or median of the composite performance scores during a prior period.**

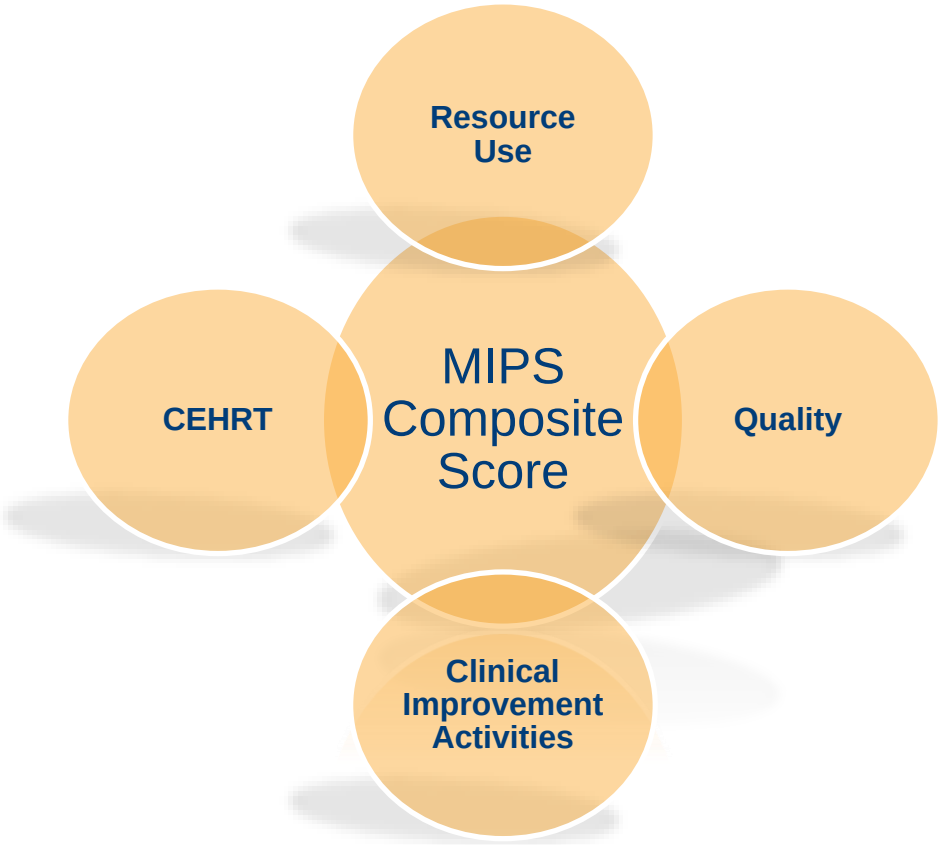
| Performance Categories* | Year 1 (2019) | Year 2 (2020) | 2021-forward |
|---|---|---|---|
| Quality | 50% | 45% | 30% |
| Resource Use | 10% | 15% | 30% |
| Clinical Practice Improvement Activities | 15% | 15% | 15% |
| Meaningful Use of EHR* | 25% | 25% | 25% |

- **Meaningful use weight can decrease to 15% and be redistributed if EHR adoption reaches 75%. If Secretary determines an EP does not have enough measures, then CMS may change weight distribution.**
- **As a MIPS or a Medical Home participant, you can receive the highest score in CPIA.**

# MIPS Performance Categories

**Performance Categories (with some flexibility)**

- Quality measures (**30%** of Score)
- Resource Use measures (**30%** of Score)
  - 2019: Counts for not more than 10%
  - 2020: Counts for not more than 15%
  - **NOTE**: Additional weight of at least 20% and 15%, respectively, are added to the quality score in those years
- CPIA(**15%** of Score)
  - Sub-categories include:
    - Expanded Practice Access
    - Population Management
    - Care Coordination
    - Patient Safety, Beneficiary Engagement
    - Others as Determined by Secretary
- Meaningful Use of EHRs (**25%** of Score)



# CMS MIPS RFI Priorities

**Priority Category One*:**

- Sub-Subsection 1 (MIPS EP Identifier and Exclusions)
- Sub-Subsection 3 (Quality Performance Category)
- Sub-Subsection 4 (Resource Use Performance Category)
- Sub-Subsection 5 (Clinical Practice Improvement Activities Performance Category)
- Sub-Subsection 6 (Meaningful Use of Certified EHR Technology Performance Category)

**Priority Category Two:**

- Sub-Subsection 2 (Virtual Groups)
- Sub-Subsection 8 (Development of Performance Standards)
- Sub-Subsection 12 (Feedback Reports)

**Priority Category Three**:

- Sub-Subsection 7 (Other Measures)
- Sub-Subsection 9 (Flexibility in Weighting Performance Categories)
- Sub-Subsection 10 (MIPS Composite Performance Score and Performance Threshold)
- Sub-Subsection 11 (Public Reporting)

- ***Areas AAMC has identified for comment**

# Draft AAMC Overarching MIPS Comments

- There should be encouragement of physician-hospital collaboration, not competition. Therefore, CMS should:
  - Propose minimal changes to the current quality programs (PQRS, MU, VM)
  - Allow maximum flexibility for meeting all requirements
- Quality and resource use measures should be adequately risk adjusted (beneficiary risk score and SES).
- Recognition for the administrative burden in reporting these metrics.
- There should be an evaluation of different reporting mechanisms to ensure that certain providers are not disproportionately impacted.
- Much of the work performed by faculty physicians should qualify as clinical practice improvement activities

**What other major comments/concerns do you have?**

# AAMC Draft Comments on Priority Category 1

**Identifiers and Exclusions:**

- Support creation of MIPS ID.
  - However, CMS should also be flexible and allow for other identifiers as well

**Quality & Resource Use Performance Categories:**

- CMS should provide multiple reporting options
- Develop a mechanism for Group reporting.
- Available measures should include process and outcome measures that are broad enough to allow for broad participation

**Clinical Practice Improvement Activities Performance Category:**

- Initial period should require attestation only for the CPIAs – must meet some of the measures, not all
- Additional examples of CPIAs
  - MOC – practice improvement projects
  - Practicing in inter-disciplinary teams
  - Participating in BPCI where the hospital is the awardee
  - Education

**Meaningful Use of Certified EHR Technology Performance Category:**

- Submissions via EHR should have a different benchmark
- Meaningful Use should be measured at group level and tiered.
- Should not be all or nothing

**Also Important to AMCs:**

- Feedback reports should be frequent and timely
- CMS should not use the ABC methodology for pubic reporting
- Establish efficient process for group practices to validate and correct information

# Alternative Payment Models (APMs)

# Overview of APM

- APM incentive payments begin January 1, 2019
- EPs can participate in MIPS or meet requirements to be a qualifying APM participant
- APM Participant
  - If criteria are met, can receive 5 percent incentive payments(2019-2024)
- Different thresholds qualify for either an APM or a Partial Qualifying APM; can measure by payments or patients
  - Threshold does not include MA revenue

# Not All APM Models Will Qualify

| Term | |
|---|---|
| Alternative Payment Model (APM) | • Model under CMMI (except innovation awards)<br>• MSSP ACO<br>• CMS demonstration projects<br>• Demonstration required under law |
| Eligible APM Entity | Entity that meets the following requirements:<br>• Participates in an APM that requires<br>  • use of CEHRT AND<br>  • payment is based on quality measures comparable to MIPS<br>And<br>  • Entity bears financial risk for monetary losses OR<br>  • Is a medical home expanded under section 1115A(c) or comparable medical home under Medicaid program |

# How do these Requirements Align with Existing APMs?

| Entity | Quality Measures Used? | Financial Risk for Physicians or CMMI Medical Home? | Use of CEHRT Required? |
|---|---|---|---|
| **MSSP ACO** | Yes | Group practice can be main participant. Gainsharing of Medicare savings permitted. | No. However, there is a quality measure regarding meaningful use |
| **Pioneer ACO** | Yes | Group practice can be main participant. Gainsharing of Medicare savings permitted. | Yes; 50% of PCPs |
| **BPCI** | Not for receiving Medicare savings. Yes for gainsharing plan and reporting to Lewin. | Group Practice can be episode initiators; physicians can also gainshare Medicare savings and internal cost savings. | No |
| **CCJR** | Yes | Yes, with gainsharing. | No |

# Thresholds Can Be Based on Medicare Or Medicare/All Payer

- To be classified as “qualifying APM participant” or “partial qualifying APM participant,” EPs have to meet or exceed certain thresholds related to eligible APM entities
- Thresholds determined by payments for services in APM but MA revenue does not count. Threshold can also be set using patients in lieu of services
- Thresholds may be determined by Medicare only services or all services (starting 2021)

| Years | Min Thresholds for Qualifying APM Participant (In payments or patients) | | Min Thresholds for Partial Qualifying APM Participant (in payments or patients) | |
|---|---|---|---|---|
| | Medicare FFS Only | Combination Medicare FFS & All-Payer | Medicare FFS Only | Combination Medicare FFS & All-Payer |
| 2019-2020 | 25% Medicare FFS | n/a | 20% Medicare FFS | n/a |
| 2021-2022 | 50% Medicare FFS **OR** | 50% Total/ 25% Medicare FFS | 40% Medicare FFS **OR** | 40% Total/ 20% Medicare FFS |
| 2023 and beyond | 75% Medicare FFS **OR** | 75% Total / 25% Medicare FFS | 50% Medicare FFS **OR** | 50% Total/ 20% Medicare FFS |

**Qualifying APM Participants are eligible for 5% bonus from 2019-2024**

# Physician Options for 2019

| Qualifying APM Participant | Partial Qualifying APM | MIPS |
|---|---|---|
| • Significant participation in APM (25%)<br>• Eligible for 5% bonuses (2019-2024)<br>• Higher update starting 2026 (0.75%)<br>• Avoid MIPS | • Lower threshold for participation (20%)<br>• No APM incentive payments<br>• Annual update same as for MIPS (0.25%);<br>• Can avoid MIPS or choose to participate in MIPs; if participate in MIPs will be subject to payment adjustment. | • EPs for first 2 years: physician, PA, NP, CNS, and CRNA<br>• 3rd year onwards: additional EPs may qualify as per the Secretary discretion<br>• Eligible for bonus from $500M pool (2019-2024)<br>• Potential payment adjustment 0.25% annual update |

# Physician-Focused Payment Models (PFPM)

Statute establishes an independent "Physician-Focused Payment Model Technical Advisory Committee" that will review, comment on, and provide recommendations to the Secretary on the proposed PFPMs

**Criteria for PFPM**

- Developed framework
- Proposed payment methodology
- How it differs from current Medicare payment methodology
- How it promotes delivery system reforms

# Selected CMS APM Priorities in the RFI

- *How should "services furnished through an EAPM entity" be defined?*
- *How should the "use" of certified EHR technology be defined?*
- *What types of "financial risk" should qualify an entity as an EAPM entity?*
- *What criteria could be considered when determining whether quality measures are comparable to MIPS?*

# Definition of APM

QPs and Partial Qualifying APMs

AAMC's comment: The agency needs to consider different contractual arrangements that exist to support practice improvement and should develop a policy that provides sufficient flexibility so that physicians are broadly encouraged to participate in APMs.

***Should CMS consider other factors to define an APM?***

Nominal Financial Risk

AAMC's comment: The agency should acknowledge that physician organizations that invest in APM infrastructure, costs are at considerable financial risk already as they have no guarantee that they will receive a positive ROI.

***What are the appropriate levels of financial risks?***

What other major comments/concerns do you have?

# Any additional questions or concerns?

# Thank you!