MACRA, MIPS, and APMs – Medicare’s Quality Payment Program:

The future of Part B Reimbursement

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Committee on Health, Public Policy, and Medical Services, Alabama Chapter
Financial Disclosures

- Board of Directors, Blue Cross Blue Shield of Alabama
- Claims and Underwriting Committee, ProAssurance
Please don’t...
Beneficiary #1

APPLICATION FOR ENROLLMENT in the Supplementary Medical Insurance Program Under the Social Security Act

PLEASE READ THE ENCLOSED LEAFLET

Harry S Truman
Independence, Missouri

TO GET MEDICAL INSURANCE

The Federal Government will pay half the cost of this insurance. Your share of the cost ($3) will be deducted from your monthly social security benefits.

IF YOU DO NOT WANT THIS MEDICAL INSURANCE

SIGN HERE

Signature by mark (X) and witnesses above

NAME OF BENEFICIARY

Harry S. Truman

CLAIM NUMBER

488-40-6969A

SEX

M

IS ENTITLED TO

Hospital Insurance 7-1-66

Medical Insurance 7-1-66

SIGN HERE
Unsustainable increases

Growth in Medicare Expenditures, Relative to 1968 Levels

Source: www.nationalaffairs.com
Sustainable Growth Rate Formula, Balanced Budget Act of 1997

Timeline: The Long Journey Toward SGR-Repeal
12 Years, 17 Patches, $169.5 billion
Cycle of volume based reimbursement
MACRA is part of a broader push toward value and quality

In January 2015, the Department of Health and Human Services announced new goals for value-based payments and APMs in Medicare

Medicare Fee-For-Service

**Goal 1: 30%**
Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018

**Goal 2: 85%**
Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018

**Stakeholders**
Consumers | Businesses | Payers | Providers | State Partners

Medicare Access and CHIP Reauthorization Act of 2015

- **Early 2014**: Congressional leaders from the House and Senate, in close collaboration with the physician community, drafted legislation which would repeal the SGR, and reward physicians for the value of the services they provide.

- **Spring 2015**: Speaker John Boehner and Minority Leader Nancy Pelosi struck a deal on the offsets and the bill passed both houses of congress with overwhelming bipartisan support.
Medicare Access and CHIP Reauthorization Act of 2015

- Signed into law April 16, 2015
- **Eliminated** the SGR
- Provides for more **predictable** Medicare payment schedule
- Congressional intent
  - **Improve care** for Medicare beneficiaries
  - **Shift payment** system from volume-based to value-based
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a bipartisan legislation signed into law on April 16, 2015.

- Merit-Based Incentive Payment System (MIPS)
- Alternative Payment Models (APMs)
Starting in 2019*, physicians will land in one of two paths: MIPS or APMs?

* This decision will actually need to be made sooner than 2019. The initial performance period for MIPS in MACRA is 2017.
Calculation of baseline payments

- January 2016 – December 2019, all physicians receive 0.5% increase per year which becomes the baseline for future reimbursement after 2019
- Starting January 2020, there will no longer be automatic baseline payment increases
- Further adjustments will be based on performance in MIPS or participation in an APM
Two pathways: MIPS versus APMs (2019)

**MIPS**

- MIPS adjusts traditional fee-for-service payments upward or downward based on new reporting program, integrating PQRS, Meaningful Use, and Value-Based Modifier
- **Measurement categories (composite score of 0-100):**
  - Clinical quality (50, 45, 30%)*
  - Meaningful use (25%)
  - Resource Use (10, 15, 30%)*
  - Practice improvement (15%)

*% weights for quality and resource use are scheduled to adjust each year until 2021

**APMs**

- Supported by their own payment rules, plus
- 5% annual bonus FFS payments (2019-2024) for physicians who get substantial revenue from alternative payment models that
  - Involve upside and downside financial risk, e.g. ACOs or bundled payments
    - OR
    - PCMHs, if ↑ quality with ↓ or ↔ cost; ↓ cost with ↑ or ↔ quality
- 0.75% annual bonus payments starting 2026
MACRA’s effects on payments beyond 2019
What is MIPS?

- Merit-Based Incentive Payment System builds on traditional fee for service by adjusting payments up or down based on performance in a new reporting system.
MIPS changes how Medicare links performance to payment

There are currently multiple individual **quality and value** programs for Medicare physicians and practitioners:

- Physician Quality Reporting Program (PQRS)
- Value-Based Payment Modifier
- Medicare EHR Incentive Program

**MACRA** streamlines those programs and a new component of **Clinical Practice Improvement Activities** into **MIPS**:

**Merit-Based Incentive Payment System (MIPS)**

What MIPS means for Medicare’s PQRS, Value-based Payment Modifier Program, and Meaningful Use ...

PQRS, VBM, and MU no longer exist as stand-alone programs starting in 2019.

2016 is the FINAL reporting period for all of these programs as stand alones!

However, the infrastructure for these programs is expected to be used for MIPS beginning in 2017.

Potential opportunity for improvement.
How will Physicians and Clinicians be Scored Under MIPS?

A single MIPS composite performance score will factor in performance in 4 weighted performance categories:

- Quality: 30%
- Resource Use: 30%
- Clinical practice improvement activities: 15%
- Meaningful use of certified EHR technology: 25%

*MIPS Composite Performance Score

*Quality component decreases from 50 to 30% and Resource use increases from 10 to 30% from 2019 to 2021

NEW Clinical Practice Improvement Activities

The subcategories shall include at least the following:

- Expanded practice access
- Population management
- Care coordination
- Beneficiary engagement
- Patient safety and practice assessment
- Participation in an APM
Clinical Practice Improvement Activities—PCMH and PCMH Specialty Practices

- “Certified” PCMH and PCMH specialty practices receive highest potential score
- Key questions (to be answered via rulemaking):
  - What will be the role of existing PCMH and PCMH specialty practice accreditation and recognition programs?
  - Will CMS consider PCMH programs that are led by other payers, states, etc.?
How Much Can MIPS Adjust Payments?

- Based on the MIPS **composite performance score**, physicians and practitioners will receive positive, negative, or neutral adjustments up to the percentages below.
- MIPS adjustments are **budget neutral**. A **scaling factor** may be applied to upward adjustments to make total upward and downward adjustments equal.

MAXIMUM Adjustments

Those who score in top 25% are eligible for an additional annual performance adjustment of up to 10%, 2019-24 (not budget neutral)

Adjustment to provider’s base rate of Medicare Part B payment

Merit-Based Incentive Payment System (MIPS)

Are there any exceptions to MIPS adjustments?

There are **3 groups** of physicians and other clinicians who will NOT be subject to MIPS:

1. **First year** of Medicare participation
2. Participants in **eligible** Alternative Payment Models who **qualify** for the bonus payment
3. Below **low volume** threshold

Note: MIPS **does not** apply to hospitals or facilities

Alternative Payment Models (APMs)
What is an APM?

- Alternative Payment Models are **new approaches for paying** for medical care through Medicare that incentivize quality and value.
Alternative Payment Models (APMs)

According to MACRA law, APMs include:

- CMS Innovation Center models (under section 1115A, other than a Health Care Innovation Award)
- MSSP (Medicare Shared Savings Program)
- Demonstration under the Health Care Quality Demonstration Program
- Other demonstration initiated by Federal Law

- MACRA does not change how any particular APM rewards value.
- APM participants who are not “Qualified Participants” will receive favorable scoring under MIPS.
- Only some of these APMs will be eligible APMs.
- Over time, more APM options will become available.

Alternative Payment Models (APMs)

- Largely involve accepting risk based on quality and effectiveness of care provided, like an ACO.
- PCMHs (initially as expanded under the CMS Innovation Center) can qualify as an APM without taking on financial risk.
Differences in APM, Eligible APM, and Qualifying APM Participants

- **Eligible APM (not all APMs are “eligible”):**
  - The **most advanced** APMs that meet the following criteria according to the MACRA law:
    - **Base payment on quality** measures comparable to those in MIPS
    - Require use of certified **EHR** technology
    - Either (1) bear more than nominal **financial risk** for monetary losses **OR** (2) be a **medical home model expanded** under CMMI authority

- **Qualifying APM participants (i.e., qualifying participants or QPs):**
  - Physicians and other clinicians who have a certain percentage of their **patients or payments** through an **eligible** APM
How does MACRA provide additional rewards for participation in APMs?

Most physicians and clinicians who participate in APMs will not qualify as QPs, but will be subject to MIPS and should receive favorable scoring under the MIPS clinical practice improvement activities performance category.

Those who participate in the most advanced APMs may be determined to be qualifying APM participants ("QPs").

1. Are not subject to MIPS
2. Receive 5% lump sum bonus payments for years 2019-2024
3. Receive a higher fee schedule update of 0.75% for 2026 and onward

Independent PFPM Technical Advisory Committee

PFPM = Physician-Focused Payment Model

Encourage new APM options for Medicare physicians and other clinicians.

Submission of model proposals → Technical Advisory Committee (11 appointed care delivery experts) → Secretary comments on CMS website, CMS considers testing proposed model

Review proposals, submit recommendations to HHS Secretary

How Will MACRA affect me?

Am I in an APM?
- YES
- NO

Am I in an eligible APM?
- YES
- NO

Do I have enough payments or patients through my eligible APM?
- YES
- NO

Is this my first year in Medicare or am I below the low-volume threshold?
- YES
- NO

Not subject to MIPS
- Subject to MIPS

Subject to MIPS:
- Subject to MIPS
- Favorable MIPS scoring
- APM-specific rewards

Qualifying APM Participant
- 5% lump sum bonus payment 2019-024
- Higher fee schedule updates 2026+
- APM-specific rewards
- Excluded from MIPS

Bottom line: There are opportunities for financial incentives for participating in an APM even if you don’t become a QP

What should you do now?

- Evaluate which option, MIPS or APM, is most available to you and feasible to take on.
- Determine if you are participating in an APM, and if so, is it one that may be an eligible APM.
- Investigate if there are APM options in your area; getting involved could provide some support and helpful services to transition to a more value-based payment system and may be beneficial to success in either MIPS or APM down the line.
PCMH as an Alternative Payment Model in MACRA

Strict definition initially:

- PCMH as expanded under the CMS Innovation Center can be an eligible APM **without taking on financial risk**
  - i.e., the Comprehensive Primary Care (CPC) Initiative

but ...

- There are lots of other PCMH programs across the country
  - Initially, they will fall under MIPS (but will score well there!)
  - However, over time this is expected to change
PCMH as an APM in the future

- Beginning in 2021, the threshold % (of payments or patients) to be an eligible APM (and a QP) may be reached through a combination of Medicare and other non-Medicare payer arrangements, such as private payers and Medicaid.

- The physician-focused payment model pathway is intended to allow for more APMs to be counted.

Bottom line ...
If you are in primary care, becoming a PCMH is the answer!
For subspecialists, becoming a PCMH neighbor/specialty practice will be a huge benefit!
Under MACRA, what’s the range of possible FFS updates and incentive payments per year? (Physicians can participate in either MIPS or APM, not both)

<table>
<thead>
<tr>
<th>Date</th>
<th>Baseline</th>
<th>MIPS (incentive adjustments), without exceptional performance adjustment*</th>
<th>Baseline, plus/minus MIPS, without exceptional performance adjustment*</th>
<th>MIPS maximum, with exceptional performance adjustment*</th>
<th>APM (FFS bonus only, does not include incentives from own APM pay structure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-1-2015</td>
<td>0% instead of 21% SGR cut</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>7-1-2015 thru 12-31-2018</td>
<td>0.5%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>2019</td>
<td>0.5%</td>
<td>+/- 4.0%**</td>
<td>= -3.5% to +4.5%**</td>
<td>14.5%</td>
<td>FFS bonus: +5%</td>
</tr>
<tr>
<td>2020</td>
<td>0%</td>
<td>+/- 5.0%**</td>
<td>= -5.0% to +5.0%**</td>
<td>15%</td>
<td>FFS bonus: +5%</td>
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<tr>
<td>2021</td>
<td>0%</td>
<td>+/- 7.0%**</td>
<td>= -7.0% to +7.0%**</td>
<td>17%</td>
<td>FFS bonus: +5%</td>
</tr>
<tr>
<td>2022, 2023 and 2024</td>
<td>0%</td>
<td>+/- 9.0%**</td>
<td>= -9.0% to +9.0%**</td>
<td>19%</td>
<td>FFS bonus: +5%</td>
</tr>
<tr>
<td>2025</td>
<td>0%</td>
<td>+/- 9.0%**</td>
<td>= -9.0% to plus 9.0%**</td>
<td>N/A</td>
<td>0%</td>
</tr>
<tr>
<td>2026 and subsequent years</td>
<td>0.25% (for non-APM physicians only)</td>
<td>+/- 9.0%**</td>
<td>= -8.75% to plus 9.25%**</td>
<td>N/A</td>
<td>0.75%</td>
</tr>
</tbody>
</table>

*Exceptional performance adjustment for those with the highest composite scores, limited to additional adjustment of 10% per year.

**HHS can increase the maximum MIPS positive adjustment (not counting the exceptional performance adjustment) to no more than 3x maximum MIPS incentive adjustment for that calendar year, if there are sufficient funds available. HHS cannot increase the maximum negative MIPS adjustment by more than the amount specified.
MACRA Implementation
MACRA Implementation Timeline

October 2015
2016 Medicare Physician Fee Schedule – Final Rule Released
Two Meaningful Use final rules released.
  • New 60-day comment period on Stage 3
A Request for Information (RFI) released from CMS on both MIPS and APM pathway implementation

Spring 2016
MU Stage 3 Final Rule
MACRA Proposed Rule
MACRA Measure Development Plan

Summer 2016
2017 Physician Fee Schedule Proposed Rule

Fall 2016
2017 Physician Fee Schedule Proposed Rule
MACRA Final Rule (for the 2017 performance period; 2019 MIPS payment adjustment period)
Annual list of MIPS quality measures (by Nov. 1 for 2017 performance period)
## Physician Payment Timeline

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<tr>
<td><strong>Anticipated annual baseline payment updates</strong></td>
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<td>Jul-Dec +0.5</td>
<td>+0.5%*</td>
<td>+0.5%</td>
<td>+0.5%</td>
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<tr>
<td><strong>Current law: PQRS, MU, VBPM</strong></td>
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<tr>
<td>Penalty up to -3.5%</td>
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<td>Penalty up to -6%</td>
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<td>Penalty up to -9%</td>
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<td>Penalty TBD</td>
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<td><strong>Merit-Based Incentive Payment System (MIPS)</strong></td>
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<td>Adjustments made on sliding scale based on performance in prior time period (TBD)</td>
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<td>Baseline payment adjustment</td>
<td>(-/+) 4%</td>
<td>(-/+) 5%</td>
<td>(-/+) 7%</td>
<td>(-/+) 9%</td>
<td>(-/+) 9%*</td>
<td>(-/+) 9%*</td>
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<tr>
<td>Maximum payment adjustment for high performers</td>
<td>+12%</td>
<td>+15%</td>
<td>+21%</td>
<td>+27%</td>
<td>+27%*</td>
<td>+27%*</td>
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<tr>
<td><strong>Legend</strong></td>
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<tr>
<td>MU = Meaningful use</td>
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<td>PQRS = Physician Quality Reporting System</td>
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<td>VBPM = Value-Based Payment Modifier</td>
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<td>RVU = Relative Value Unit</td>
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**Alternative Payment Models (APMs)**

- 5% annual bonus – Paid in lump sum
- Participants are exempt from MIPS.

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*The projected 0.5% update, established by MACRA, was negated due to other legislative provisions. As a result, the 2016 conversion factor will be $35.82 instead of $35.93, which is a net reduction of 11 cents per Relative Value Unit (RVU).

*Lowest quartile performers automatically receive the maximum negative payment adjustment.

*Payment adjustment listed for 2023 through 2024 is an assumption based on currently available information.

*Exceptional performance criteria has not been defined.
Summary of CY 2018 Payment Adjustments

- Based on reporting in performance year 2016
  - PQRS: -2.0 percent for failing to satisfactorily report
  - Meaningful Use of EHRs: -3.0 percent for failing to attest to MU
  - Value-based Payment Modifier maximum downward adjustments:
    - -4.0 percent for groups of 10 or more EPs
    - -2.0 percent for solo and groups of 2 – 9 EPs
MACRA’s impact

How MACRA's initial impact breaks down
The first performance year begins Jan. 1 for payments in 2019

761,342
Number of clinicians eligible for the Merit-based Incentive Payment System (MIPS)

30,658-90,000
Number that could be exempt from MIPS and get a bonus for participating in an advanced Alternative Payment Model (APM)

Components of MIPS

15% Clinical practice improvement
25% Advancing Care Information (replaces EHR meaningful use)
50% Quality (replaces Physician Quality Reporting System and Value-based Payment Modifier)
10% Cost

Maximum bonus or penalty under MIPS in 2019:
+4% Medicare bonus in 2019 for participating in an advanced APM:
5%

Source: CMS
MACRA’s impact

Solo and small practices will get hit hardest under the new incentive payment system

<table>
<thead>
<tr>
<th>Practice size</th>
<th>Eligible clinicians</th>
<th>Percentage likely to be penalized</th>
<th>Percentage likely to get bonus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo</td>
<td>102,788</td>
<td>87%</td>
<td>12.9%</td>
</tr>
<tr>
<td>2-9</td>
<td>123,695</td>
<td>69.9%</td>
<td>29.8%</td>
</tr>
<tr>
<td>10-24</td>
<td>81,207</td>
<td>59.4%</td>
<td>40.3%</td>
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<tr>
<td>25-99</td>
<td>147,976</td>
<td>44.9%</td>
<td>54.5%</td>
</tr>
<tr>
<td>100 or more</td>
<td>305,676</td>
<td>18.3%</td>
<td>81.3%</td>
</tr>
<tr>
<td>Overall</td>
<td>761,342</td>
<td>45.5%</td>
<td>54.1%</td>
</tr>
</tbody>
</table>

Source: CMS
Highlights of ACP Comments on MACRA RFI

- Called on CMS to use the opportunity provided through the new MACRA law to build a learning health and healthcare system.
- Recommended that CMS work to ensure that patients, families, and the relationship of patients and families with their physicians are at the forefront of the Agency’s thinking.
Additional ACP RFI Comments: Key Principles for MACRA Implementation

- Support delivery system improvements.
- Avoid administrative and cost burdens for patients.
- Reduce administrative burdens for physicians.
- Improve current quality and reporting systems.
- Recognize patient diversity.
- Provide choice of payment models.
- Be equitable.
- Be relevant and actionable.
- Provide stability and resources.
- Be transparent.
How Can ACP Help You to Succeed?
MIPS or APM? ACP plans to help members choose the right path

1. **Advocacy** so that whatever path they choose, it gets them to a destination of higher quality, more cost-effective care, without unnecessary obstacles, barriers, potholes, and detours along the way!

2. **Education & Resources** to help them succeed (e.g. Practice Advisor, Genesis Registry, PQRS Wizard, Timeline)

3. **Decision tool (?)** to guide them on which path to take, MIPS or APMs
Sources for assistance

- ACP online Running a Practice (www.acponline.org/running_practice/)
- Physician & Practice Timeline (text alerts—acptimeline to 313131) (www.acponline.org/running_practice/physician_practice_timeline/)
- ACP Practice Advisor® (www.practiceadvisor.org/) will be growing through ACP’s CMS Innovation Center Support & Alignment Network (SAN) grant
- AmericanEHR (www.americanehr.com/)—data from physicians for physicians on EHR selection and usability, including MU cert.
- PQRS Wizard (www.pqrswizard.com/)
- Genesis Registry (for PQRS, MU, etc.)—QCDR (www.medconcert.com/content/medconcert/Genesis/)