MACRA: Preparing for the Road Ahead

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DISCLOSURE:

In accordance with the guidelines of the Florida Medical Association/Accreditation Council for Continuing Medical Education, Dr. Mayzell has indicated that he has no conflict of interest to disclose that will affect his ability to present an unbiased presentation.
Payment Goals of U.S. Healthcare

Shift from FFS to Alternative Payment Models (APMs)

- **2016**
  - 30%
  - In 2016, at least 30% of payments linked to quality and value through APMs

- **2018**
  - 50%
  - In 2018, at least 50% of payments linked to quality and value through APMs
Medicare Payment Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on volume of services, not value.

The Sustainable Growth Rate (SGR)

- Established in 1997 to control the cost of Medicare payments to physicians

IF

Overall physician costs > Target Medicare expenditures

Physician payments cut across the board

Each year, Congress passed temporary “doc fixes” to avert cuts (no fix in 2015 would have meant a 21% cut in Medicare payments to clinicians)
MACRA is Here to Stay
MACRA: Medicare Access and CHIP Reauthorization Act

- In April 2015 the Medicare Access and CHIP Reauthorization Act (MACRA) went into law in a historic bipartisan way and replaced the Sustainable Growth Rate (SGR) formula
  - A new performance-based payment system with financial incentives for participation in Alternative Payment Models and the new Merit-based Incentive Payment System (MIPS)

- In April 2016 CMS releases a proposed rule (900+ pages) establishing rules for Advanced Alternative Payment Models (APMs) and the Merit-based Incentive Payment System (MIPS)
  - Introduces the Quality Payment Program (QPP)
  - Comments were due back by June 27, 2016
MACRA’s Quality Payment Program (QPP)

BUT

WHAT DOES IT ALL MEAN?
Two Paths Under MACRA’s Quality Payment Program

Providers in either Pay for Performance (MIPS) or Advanced APM

Merit Based Incentive Payment System (MIPS)

Combines the current Physician Quality Reporting System (PQRS), the Value Modifier (VM), and Meaningful Use (MU) programs into a single pay-for-performance payment system

Advanced Alternative Payment Models (APMs)

Provides incentives for provider participation in certain alternative payment models based on proposed criteria
Merit Based Incentive Payment System (MIPS)
Participation in MIPS

Who will participate?

**Years 1 and 2**
Medicare Part B eligible clinicians referred to as “MIPS eligible clinicians”
- MD/DO
- Physician Assistants
- Nurse Practitioners
- Clinical nurse specialists
- CRNAs
- Groups of above

**Years 3+**
HHS Secretary may broaden MIPS Eligible Clinicians such as
- Physical Therapists
- Speech Pathologists
- Audiologists
- Nurse midwives
- Clinical psychologists
- Dietitians / Nutritionist

Who will NOT participate?

1st year of Medicare Part B participation

Low patient volume; Medicare billing charges ≤ $10,000 and 100 or fewer Medicare patients in one year

Participants in Advanced Alternative Payment Models
Measurement Period is Approaching Fast

- **April 2015**: MACRA Law Introduced
- **2016**: CMS issues proposed rule: Quality Payment Program
- **January 2017**: Performance measurement period begins
- **January 2019**: Based on eligibility, APM or MIPS payment adjustment starts
How is Performance Categorized in MIPS?

4 Categories

1. Quality
2. Resource Use
3. Clinical Practice Improvement Activities
4. Advancing Care Information

Weighting

2019 MIPS PAYMENT YEAR
- Quality: 25%
- Advancing Care Information*: 15%
- CPIA: 15%
- Resource Use: 10%

2020 MIPS PAYMENT YEAR
- Quality: 25%
- Advancing Care Information*: 45%
- CPIA: 15%
- Resource Use: 15%

2021+ MIPS PAYMENT YEAR
- Quality: 25%
- Advancing Care Information*: 30%
- CPIA: 15%
- Resource Use: 30%

*The weight for advancing care information could decrease (not below 15 percent) if the Secretary estimates that the proportion of physicians who are meaningful EHR users is 75 percent or greater. The remaining weight would then be reallocated to one or more of the other performance categories.
How is Performance Determined in MIPS?

Composite Performance Score (CPS)

Quality performance category score \times \text{Quality performance category weight} +

Resource Use performance category score \times \text{Resource Use performance category weight} +

CPIA performance category score \times \text{CPIA performance category weight} +

Advancing Care Information performance category score \times \text{Advancing Care Information performance category weight}

\times 100

0-100 point scale
Financial Incentives and Adjustments Through MIPS

Exceptional performers receive additional positive adjustment factor (not to exceed 10%) up to $500M available each year from 2019 to 2024

Eligible Providers above performance threshold = positive payment adjustment

*MACRA allows potential 3x upward adjustment BUT unlikely

Note: MIPS will be a budget-neutral program. Total upward and downward adjustments will be balanced so that the average change is 0%.

CMS Proposed Rule Table 63: MIPS PROPOSED RULE ESTIMATED IMPACT ON TOTAL ALLOWED CHARGES BY SPECIALTY: MID-POINT ESTIMATE (2014 Data to estimate 2017 performance)
CMS’ Projected MIPS Impact by Practice Size

CMS’ Projected MIPS Financial Impact by Practice Size (in Millions)

Dollars (in millions)

- Solo
- 2-9 eligible clinicians
- 10-24 eligible clinicians
- 25-99 eligible clinicians
- 100 or more eligible clinicians
CMS’ Projected MIPS Impact by Specialty

CMS’ Projected MIPS Percent of Payment Adjustment by Specialty

Specialty Type

- Percent with Negative Payment Adjustment
- Percent with Positive Payment Adjustment

Vizient Southeast Presentation │ September 19, 2016 │ Confidential Information
MIPS Quality Scoring
Quality Performance Category (Think PQRS)

✓ Report at least 6 measures, including one cross-cutting measure and at least one outcome measure.
  - If an outcome measure is not available report another high priority measure
  - If fewer than 6 measures apply then report on each measure that is applicable.

✓ Select measures from either the list of all MIPS Measures or a set of specialty specific measures.

✓ EHR, registries need to report on at least 90% of patients; Medicare Part B claims report 80% of patients

✓ Population measures automatically calculated
## Key Changes from Current Program (PQRS)

<table>
<thead>
<tr>
<th>Scoring</th>
<th>PQRS</th>
<th>Proposed MIPS Quality Performance Category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Report all required measures to avoid payment adjustment</td>
<td>Report all required measures. Credit received for those measures that meet the data completeness threshold. Eligible clinicians performance will influence their score</td>
</tr>
<tr>
<td>Data Submission Criteria</td>
<td>Required 9 measures across 3 National Quality Strategy (NQS) domains</td>
<td>Requires 6 measures; no NQS domain requirement</td>
</tr>
<tr>
<td>Consumer Assessment of Healthcare Providers and Systems (CAHPS) Requirement</td>
<td>CAHPS required for groups with 100 or more EPs</td>
<td>CAHPS no longer required for groups of 100 or more, but clinicians can receive bonus points for electing CAHPS</td>
</tr>
</tbody>
</table>
MIPS Proposed Cross-Cutting Measures

- **Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

- **Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter.

- **Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.

- **Controlling High Blood Pressure:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement period.

- **Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.

- **Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.

- **Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.

- **Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user.

- **Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter.
### MIPS Specialty Measure Sets for Cardiology

<table>
<thead>
<tr>
<th>MIPS ID Number</th>
<th>NQF PQRS Measure ID</th>
<th>CMS E-Measure ID</th>
<th>Data Submission Method</th>
<th>Measure Type</th>
<th>National Quality Strategy Domain</th>
<th>Measure Title and Description</th>
<th>Measure Steward</th>
</tr>
</thead>
<tbody>
<tr>
<td>§ 0081/005</td>
<td>135v4</td>
<td>Registry, EHR</td>
<td>Process</td>
<td>Effective Clinical Care</td>
<td>Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) &lt; 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge</td>
<td>American Medical Association-Physician Consortium for Performance Improvement/American College of Cardiology Foundation/ American Heart Association</td>
<td></td>
</tr>
<tr>
<td>!! N/A/322</td>
<td>N/A</td>
<td>Registry</td>
<td>Efficiency</td>
<td>Efficiency and Cost Reduction</td>
<td>Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients Percentage of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed in low risk surgery patients 18 years or older for preoperative evaluation during the 12-month reporting period</td>
<td>American College of Cardiology</td>
<td></td>
</tr>
<tr>
<td>! 2474/392</td>
<td>N/A</td>
<td>Registry</td>
<td>Outcome</td>
<td>Patient Safety</td>
<td>HRS-12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation Rate of cardiac tamponade and/or Pericardiocentesis following atrial fibrillation ablation This measure is reported as four rates stratified by age and gender: • Reporting Age Criteria 1: Females less than 65 years of age • Reporting Age Criteria 2: Males less than 65 years of age • Reporting Age Criteria 3: Females 65 years of age and older • Reporting Age Criteria 4: Males 65 years of age and older</td>
<td>The Heart Rhythm Society</td>
<td></td>
</tr>
</tbody>
</table>

Note: Existing measures with proposed substantive changes are noted with an asterisk (*), new proposed measures are noted with a plus symbol (+), core measures as agreed upon by Core Measure Collaborative are noted with the symbol (§), high priority measures are noted with an exclamation point (!), and high priority measures that are appropriate use measures are noted with a double exclamation point (!!), in the “MIPS ID Number” column.
## MIPS Specialty Measure Sets for Gastroenterology

<table>
<thead>
<tr>
<th>MIPS ID Number</th>
<th>NQF/PO RS</th>
<th>CMS Measure ID</th>
<th>Data Submission Method</th>
<th>Measure Type</th>
<th>National Quality Strategy Domain</th>
<th>Measure Title and Description</th>
<th>Measure Steward</th>
</tr>
</thead>
<tbody>
<tr>
<td>§</td>
<td>34</td>
<td>130v4</td>
<td>Claims, Web Interface, Registry, EHR</td>
<td>Process</td>
<td>Effective Clinical Care</td>
<td>Colorectal Cancer Screening Percentage of patients 50 - 75 years of age who had appropriate screening for colorectal cancer</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>§!!</td>
<td>659</td>
<td>N/A</td>
<td>Claims, Registry</td>
<td>Process</td>
<td>Communication and Care Coordination</td>
<td>Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior adenomatous polyp(s) in previous colonoscopy findings, who had an interval of 3 or more years since their last colonoscopy</td>
<td>American Medical Association- Physician Consortium for Performance Improvement American / Gastroenterological Association/ American Society for Gastrointestinal Endoscopy/ American College of Gastroenterology</td>
</tr>
<tr>
<td>§!!</td>
<td>N/A/439</td>
<td>N/A</td>
<td>Registry</td>
<td>Efficiency</td>
<td>Efficiency and Cost Reduction</td>
<td>Age Appropriate Screening Colonoscopy The percentage of patients greater than 85 years of age who received a screening colonoscopy from January 1 to December 31</td>
<td>American Gastroenterological Association/ American Society for Gastrointestinal Endoscopy/ American College of Gastroenterology</td>
</tr>
</tbody>
</table>

Note: Existing measures with proposed substantive changes are noted with an asterisk (*), new proposed measures are noted with a plus symbol (+), core measures as agreed upon by Core Measure Collaborative are noted with the symbol (§), high priority measures are noted with an exclamation point (!), and high priority measures that are appropriate use measures are noted with a double exclamation point (!!), in the “MIPS ID Number” column.
Quality Performance Category Scoring

- Each measure is converted to points (1-10)
- Zero points for a measure that is not reported
- Bonus for reporting additional outcomes, appropriate use, patient experience & safety
- Bonus for EHR Reporting

Total Points

Total Possible points

Quality Performance Category Score
Quality Performance Category Scoring: Converting Measure to Points Based on Deciles

<table>
<thead>
<tr>
<th>Each measure is converted to points (1-10)</th>
<th>Decile Rank</th>
<th>Decile 1</th>
<th>Decile 2</th>
<th>Decile 3</th>
<th>Decile 4</th>
<th>Decile 5</th>
<th>Decile 6</th>
<th>Decile 7</th>
<th>Decile 8</th>
<th>Decile 9</th>
<th>Decile 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible Points</td>
<td>1.0-1.9</td>
<td>2.0-2.9</td>
<td>3.0-3.9</td>
<td>4.0-4.9</td>
<td>5.0-5.9</td>
<td>6.0-6.9</td>
<td>7.0-7.9</td>
<td>8.0-8.9</td>
<td>9.0-9.9</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

For each measure:

- CMS publishes deciles based on national performance in a baseline period (2-years prior to the performance period)
  - Exception – Performance period is used if a baseline benchmark is not available
- Eligible clinician’s performance is compared to the published decile breaks
- Points are assigned based on which decile range the performance data is located. All scored measures receive at least 1 point
  - Partial points are assigned within deciles based on percentile distribution.
- Rules for special cases:
  - Eligible clinicians with performance in the top decile will receive the maximum 10 points
  - Eligible clinicians who do not report enough measures will receive 0 points for each measure not reported, unless they could not report these measures due to insufficient applicable measures
### Example: Assigning Points Based on Deciles

<table>
<thead>
<tr>
<th>Decile Rank</th>
<th>Decile 1</th>
<th>Decile 2</th>
<th>Decile 3</th>
<th>Decile 4</th>
<th>Decile 5</th>
<th>Decile 6</th>
<th>Decile 7</th>
<th>Decile 8</th>
<th>Decile 9</th>
<th>Decile 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible POINTS</td>
<td>1.0-1.9</td>
<td>2.0-2.9</td>
<td>3.0-3.9</td>
<td>4.0-4.9</td>
<td>5.0-5.9</td>
<td>6.0-6.9</td>
<td>7.0-7.9</td>
<td>8.0-8.9</td>
<td>9.0-9.9</td>
<td>10</td>
</tr>
</tbody>
</table>

0% | 7% | 16% | 23% | 36% | 41% | 62% | 69% | 79% | 85% | 100% |

*Example of decile breaks for a specific quality measure*

Eligible clinician with 19% performance rate would get approximately 3.3 points (based on distribution within the decile).

Eligible clinician with 95% performance rate would get 10 points.
### Scoring Example:
**Dr. Joy Smith Submitted the following:**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Type</th>
<th>Number of Cases</th>
<th>Points Based on Performance</th>
<th>Total Possible Points (10 x Weight)</th>
<th>Quality Bonus Points For High Priority</th>
<th>Quality Bonus Points for EHR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure 1</td>
<td>Outcome Measure using CEHRT</td>
<td>20</td>
<td>4.1</td>
<td>10</td>
<td>0 (required)</td>
<td>1</td>
</tr>
<tr>
<td>Measure 2</td>
<td>Process using CEHRT</td>
<td>21</td>
<td>9.3</td>
<td>10</td>
<td>N/A</td>
<td>1</td>
</tr>
<tr>
<td>Measure 3</td>
<td>Process using CEHRT</td>
<td>22</td>
<td>10</td>
<td>10</td>
<td>N/A</td>
<td>1</td>
</tr>
<tr>
<td>Measure 4</td>
<td>Process</td>
<td>50</td>
<td>10</td>
<td>10</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Measure 5</td>
<td>High Priority- Patient Safety</td>
<td>43</td>
<td>8.5</td>
<td>10</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>Measure 6 (Missing)</td>
<td>Cross-Cutting</td>
<td>N/A</td>
<td>0</td>
<td>10</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Acute Composite</td>
<td>Admin. Claims</td>
<td>10</td>
<td>Not scored: below minimum sample size</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Chronic Composite</td>
<td>Admin. Claims</td>
<td>20</td>
<td>6.3</td>
<td>10</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>All-Cause Hospital Readmission</td>
<td>Admin. Claims</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Total Points</td>
<td>All Measures</td>
<td>N/A</td>
<td>48.2</td>
<td>70</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>
Each measure is converted to points (1-10) + Zero points for a measure that is not reported + Bonus for reporting additional outcomes, appropriate use, patient experience & safety + Bonus for EHR Reporting = Total Points

Dr. Smith has 48.2 points based on performance + Zero points + She qualifies for 1 bonus point for reporting an additional high priority measure + She gets 3 bonus points for using their EHR to report quality measures = She gets 52.2 Total Points

Total Points ÷ Total Possible points = Quality Performance Category Score

52.2 Total Points ÷ 70 Total Possible points = 74.5% Quality Score

Dr. Smith earns 37.3 points toward her MIPS Composite Performance Score (74.6% x 50% weight for Quality)
Continuation of two measures from Value Modifier (VM)
  - Total per costs capita for all beneficiaries
  - Medicare Spend per Beneficiaries (MSPB)

Key Changes from current program (Value Modifier):
  - Adding 40+ episode specific measures to address specialty concerns; final list uncertain until Final Rule
  - Year 1 Weight: 10%
  - Attribution using Tax ID/NPI versus TIN

Assign 1-10 points to each measure based on performance year

Assessment under all available resource use measures, as applicable to the clinician

CMS calculates based on claims so there are no reporting requirements for clinicians
New performance category

Minimum selection of one CPIA activity (from 90+ proposed activities) with additional credit for more activities examples include:
  • Care coordination
  • Expanding practice access
  • Shared decision making

Must perform CPIA for at least 90 days to receive credit

Full credit for patient-centered medical home

Minimum of half credit for APM participation

Key Changes from Current Program:
  • Not applicable (new category)
  • Year 1 Weight: 15%
Clinical Practice Improvement Activity: Scoring Methodology

- MIPS eligible clinicians receive a potential score of **60 points** based on patient-centered medical home or comparable specialty practice participation, APM participation, and reported CPIA.

**CMS assigns points for each reported CPIA within two weights**

- Medium-weighted: 10 Points
- Heavy-weighted: 20 Points

- Full credit if certified as a patient-centered medical home or comparable specialty practice.
- Small practices (consisting of <15 professionals) and practices located in rural areas receive 50% credit for selecting one or 100% credit for selecting two weighted activities.
- Eligible clinicians in an APM, but not qualified for Advanced APM, receive 50% credit (30 points).
Subcategories of Clinical Practice Improvement Activities

<table>
<thead>
<tr>
<th>Expanded Practice Access</th>
<th>Beneficiary Engagement</th>
<th>Achieving Health Equity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Coordination</td>
<td>Participation in an APM, including a medical home model</td>
<td>Integrated Behavioral and Mental Health</td>
</tr>
</tbody>
</table>
Scoring Dr. Joy Smith: CPIA Performance Category

Total points for high-weight activities + Total points for medium-weight activities = Total CPIA Points

Dr. Smith completes 2 high-weight activities (earning her 40 points) + She also completes 1 medium-weight activities (earning her 10 points) = She gets 50 total points

Total CPIA Points ÷ Total Possible points = CPIA Performance Category Score

50 Total Points ÷ 60 Total Possible points = 83% CPIA Score

Dr. Smith earns 12.5 points toward her MIPS Composite Performance Score (83% x 15% weight for CPIA)
Advancing Care Information Performance Category

- Scoring based on key measures of health IT interoperability and information exchange.
- Flexible scoring for all measures to promote care coordination for better patient outcomes
- Key Changes from Current Program (EHR Incentive):
  - Dropped “all or nothing” threshold for measurement
  - Removed redundant measures to alleviate reporting burden
  - Eliminated Clinical Provider Order Entry and Clinical Decision Support objectives
  - Reduced the number of required public health registries to which clinicians must report
  - Year 1 Weight: 25%
Overview: Advancing Care Information Performance Category

Overall Advancing Care Information score is a combination of a base score and a performance score for a maximum score of 100 points.

Score capped at 100 points with greater than 100 points available to allow more flexibility to achieve the maximum score.
Advancing Care Information Performance Category

Base Score

Score based on submitting numerator / denominator or yes/no for six objectives and their measures

- Protect Patient Health Information (yes required)
- Electronic Prescribing (numerator/denominator)
- Patient Electronic Access (numerator/denominator)
- Coordination of Care Through Patient Engagement (numerator/denominator)
- Health Information Exchange (numerator/denominator)
- Public Health and Clinical Data Registry Reporting (yes required)
Score based performance rate for a given measure, each worth 10 points, across three objectives.

- **Patient Access**
  - Patient Access
  - Patient Specific Education

- **Coordination of Care Through Patient Engagement**
  - View, Download, Transmit
  - Secure Messaging
  - Patient Generated Health Data

- **Health Information Exchange**
  - Patient Care Record Exchange
  - Clinical Information Reconciliation
  - Request/Accept Patient Care Record

Account for **80 points** of the total Advancing Care Information Performance Category Score.
# Summing Up the Composite Performance Score (CPS)

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
<th>Scoring</th>
</tr>
</thead>
</table>
| Quality                | 50%    | • 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 |
| Resource Use           | 10%    | • Similar to quality                                                                                                                                 |
| CPIA                   | 15%    | • Each activity worth 10 points; 20 points for “high” value activities; sum of activity points compared to a target |
| Advancing care        | 25%    | • Base score of 60 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 |

**Unified scoring system:**
1. Converts measures/activities to points
2. Eligible Clinicians will know in advance what they need to do to achieve top performance
3. Partial credit available
# How Can Data be Submitted for MIPS?

## Individual Reporting

<table>
<thead>
<tr>
<th></th>
<th>Claims</th>
<th>QCDR</th>
<th>Qualified Registry</th>
<th>EHR Vendors</th>
<th>Administrative Claims (no submission required)</th>
<th>CMS Web Interface (groups &gt;25)</th>
<th>Attestation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Resource Use</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPIA</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

## Group Reporting

<table>
<thead>
<tr>
<th></th>
<th>CAHPS for MIPS</th>
<th>QCDR</th>
<th>Qualified Registry</th>
<th>EHR Vendors</th>
<th>Administrative Claims (no submission required)</th>
<th>CMS Web Interface (groups &gt;25)</th>
<th>Attestation</th>
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<tbody>
<tr>
<td>Quality</td>
<td>✓</td>
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<td>Resource Use</td>
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</table>
September 8, 2016 CMS issued new proposals for MACRA

Choosing one of these 4 options would “ensure” providers do not receive a negative payment adjustment in 2019. These options and other supporting details will be described fully in the final rule.

1. First Option: Test the Quality Payment Program (QPP)
   - Submit some data and avoid a negative payment adjustment

2. Second Option: Participate for part of the calendar year
   - Participate for a reduced number of days and possibly receive a “small” payment adjustment

3. Third Option: Participate for the full calendar year
   - Start participation on 01/01/2017 and possibly receive a “modest” payment adjustment

4. Fourth Option: Participate in an Advanced Alternative Payment Model in 2017
   - Excluded from MIPS and automatically receive 5% lump sum on Medicare Part B payments
Advanced Alternative Payment Model
What is an Eligible Advanced APM?

Eligible APMs are 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
How Do I Become a Qualifying APM Participant (QP)?

You must have a certain % of your patients or payments through an Advanced APM.

- Advanced APMs are not subject to MIPS
- Receive 5% lump sum bonus payments for years 2019-2024
- Receive a higher fee schedule update for 2026 and onward

**QUALIFICATION**

You have a certain % of your patients or payments through an Advanced APM

**Option #1**

- % of Medicare revenue through Advanced APMs

**Option #2**

- % of Medicare revenue combined with All-Payer revenue through Advanced APMs in 2021
Advanced Alternative Payment Models (APM)

- Must meet minimum Medicare Part B payments or patient thresholds within the following Advanced APMs to become QP
  - Comprehensive ESRD Care (CEC)
  - Comprehensive Primary Care Plus (CPC+)
  - Medicare Shared Savings Program – Track 2 & 3 (MSSP)
  - Next Generation ACO
  - Oncology Care Model – 2 sided risk (OCM)
  - CJR* (SHFFT Model Qualifies in 2018 with downside risk)
  - CMS Cardiac Care Bundle* (Qualifies in 2018 with downside risk)

*Proposed in HHS Episode Payment Model
Advanced APMs

- **CJR* (SHFFT Model Qualifies in 2018 with downside risk)**
  - 90 day episode post hospitalization
  - Target price calculated by CMS
  - Reconciliation payments with performance component
  - Moves quickly to upside and downside risk for hospital system

- **CMS Cardiac Care Bundle* (Qualifies in 2018 with downside risk)**
  - Includes AMI, CABG, and PCI
  - 90 day episode
  - Target pricing reconciliation payment
  - Moves to upside and downside risk
  - Separate fee-for-service payment incentive for cardiac rehab
Adding it Up

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee Schedule</th>
<th>MIPS</th>
<th>Advanced APMs</th>
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<td>2016</td>
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<td>2018</td>
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<td>0</td>
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</tr>
<tr>
<td>2019</td>
<td>+0.5% each year</td>
<td>No Change</td>
<td>5% bonus (excluded from MIPS)</td>
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<tr>
<td>2020</td>
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<td>5% bonus (excluded from MIPS)</td>
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<td>2021</td>
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<td>5% bonus (excluded from MIPS)</td>
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<tr>
<td>2022</td>
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<td>No Change</td>
<td>5% bonus (excluded from MIPS)</td>
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<tr>
<td>2023</td>
<td>+0.5% each year</td>
<td>No Change</td>
<td>5% bonus (excluded from MIPS)</td>
</tr>
<tr>
<td>2024</td>
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<td>5% bonus (excluded from MIPS)</td>
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<tr>
<td>2025</td>
<td>+0.5% each year</td>
<td>No Change</td>
<td>5% bonus (excluded from MIPS)</td>
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<td>2026+</td>
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<td>+4%</td>
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Summary - Key Take Away

- MACRA Law is here to stay; 90% House and Senate passed

- Medicare Part B clinicians will participate in the MIPS, unless they are in their 1st year of Part B participation, become QPs through participation in Advanced APMs, or have a low volume of patients

- Performance measurement will begin in 2017

- Payment adjustments and bonuses will begin in 2019

- Budget Neutral

- More Advanced APM opportunities (i.e. CJR, Cardiac…)

- Assume there will be quality transparency
Action Steps

Take Action Now

- Learn and understand MACRA
- Talk to your EMR vendor and understand the capabilities
- If no EMR, think of a strategy to deliver data
- Consider and evaluate administrative complexity and cost (i.e. group, CIN, Hospital)
- Make a plan
- Do something in year one, don’t forfeit income
- Year 2 may have large upside?
For more information, please contact:
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