Navigating Medicare’s Quality Payment Program:
A Comprehensive Primer for Physicians

Physicians Advocacy Institute
MACRA Educational Series
March 2017
About the Physicians Advocacy Institute

The Physicians Advocacy Institute (PAI) is a not-for-profit organization that was established to advance fair and transparent policies in the health care system to sustain the profession of medicine for the benefit of patients.

As part of this mission, PAI seeks to better understand the challenges facing physicians and their patients and also educate policymakers about these challenges.

PAI also develops tools to help physicians prepare for and respond to policies and marketplace trends that impact their ability to practice medicine.

Information about PAI can be found at physiciansadvocacyinstitute.org.
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Healthsperien is a Washington, D.C.–based consulting and legal services firm focused on strategic issues operating at the intersection of public policy, business strategies, operations, and government affairs.

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Information about Healthsperien can be found at [http://healthsperien.com/](http://healthsperien.com/).
Guide to the PAI MACRA Educational Series

• **Overall purpose** – Program of materials and resources that provide context, an overview of core concepts and requirements, and an in-depth discussion of important topics

• **MACRA overview** – Foundational presentation and associated webinars to include a focus on meeting requirements for the 2017 transition period. Includes different sections on aspects of MACRA’s Quality Payment Program.

• **Follow-on products in early 2017** – In-depth one-pagers and monographs focused on topics such as the MIPS scoring system and strategies for reporting

• **In development** – Guide to additional resources in physician communities
Acronyms

- ACI – Advancing Care Information Category
- APMs – Alternative Payment Models
- CEHRT – Certified EHR Technology
- EHR/EMR – Electronic Health Registry; Electronic Medical Record
- MACRA – Medicare Access and CHIP Reauthorization Act
- MIPS – Merit-Based Incentive Payment System
- PQ – Partially Qualifying Advanced APM Participant
- QCDR – Qualified Clinical Data Registry
- QP – Qualifying Advanced APM Participant
- QPP – Quality Payment Program
What to find in this presentation . . .

1) MACRA’s QPP at 30,000 feet
   • From SGR to MACRA (slide 9)
   • Goals of the New Payment System (slide 10)
   • Two Pathways for Physicians to Choose from: MIPS and Advanced APMs (slide 11)
   • Payment Adjustments Associated with each Pathway (slide 12)
   • Concerns Heard from PAI Members and Practical Challenges (slide 13)

2) 2017 Transition Year Minimum Reporting Options
   • 2017 Opportunities for Easy Reporting (slide 16)

3) Pathway 1: Merit-based Incentive Payment System (MIPS)
   • Overview of MIPS Categories (slide 19)
   • Participation Eligibility and Exemptions (slide 20)
   • Reporting Mechanisms and Options (slide 22)
   • Overview of Approach to Performance Measurement and Payment Adjustments (slide 26)

4) Reporting Timeline (slide 31)

5) Next Steps and Looking Forward
   • Should I Select the MIPS Pathway? (slide 33)
MACRA’s QPP at 30,000 feet
From SGR to MACRA

• MACRA = Medicare Access and CHIP Reauthorization Act of 2015
• Next phase of Medicare fee-for-service payments under Part B

• What does the new system do?
  • Replaces annual updates under Sustainable Growth Rate (SGR) with the Quality Payment Program (QPP)
  • Introduces new opportunities for positive and negative payment adjustments of Medicare Part B payments
  • Combines three quality performance programs (PQRS, value-based payment modifier, meaningful use) into a single program under the QPP

• Regulations finalized in November 2016; final rule went into effect January 1, 2017
• Payment changes begin in 2019 (based on 2017 performance)
Goals of the new payment system

1. Create a new Medicare payment system for physicians (and certain other eligible clinicians) across all specialties that is meaningful and flexible
2. Improve patient outcomes and engage patients
3. Encourage physicians to improve performance with “carrots and sticks”
4. Increase the availability of and participation in risk-based models of care
5. Support broad physician participation, including small/solo practices
6. Simplify complex and multiple reporting and performance systems

Source: CMS MIPS and APM final rule
Two pathways for physicians to choose from

### Merit-based Incentive Payment System (MIPS)
- Fee-for-service annual updates
- New set of positive and negative payment adjustments
- 4 performance categories
  - Cost
  - Quality
  - Improvement activities
  - Advancing care information
- Opportunities to participate in alternative payment models (MIPS APMs)

### Advanced Alternative Payment Models (APMs)
- Enhanced fee-for-service annual updates
- Exempt from MIPS participation
- Payment incentive for participation in risk-based payment models
  - CMS has identified eligible models
  - More models to evolve
- May earn a 5% payment incentive each year 2019-2024
- May earn a 0.75% annual Medicare Part B physician fee schedule update for successful participation in Advanced APMs beginning 2026
  - Those who do not participate successfully in Advanced APMs would receive a 0.25% annual update and may also be subject to MIPS reporting requirements and payment adjustments
Medicare payment adjustments depend on the pathway selected...

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<tr>
<td>Annual fee schedule updates* (all physicians)</td>
<td>+0.5%</td>
<td>+0.5%</td>
<td>+0.5%</td>
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<td></td>
<td></td>
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<td>Non-APM: 0.25%</td>
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<tr>
<td>MIPS**</td>
<td>+/-4%</td>
<td>+/-5%</td>
<td>+/-7%</td>
<td>+/-9%</td>
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<tr>
<td>Advanced APMs (Qualifying Participants)</td>
<td>+5%</td>
<td>+5%</td>
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*Annual physician fee schedule updates may be downwardly adjusted by other budgetary requirements
**Due to CMS transition relief policies in 2017, available funds may be insufficient to grant a full 4% incentive payment in 2019; additionally, physicians have the potential to receive an additional positive payment adjustment for exceptional performance for payment years 2019-2024
Concerns heard from PAI members

• Disconnect between MACRA and everyday practice

• Unclear nexus between program/reporting requirements and clinical quality improvement. Physicians feel burdened with meeting the program requirements, but fail to see how the requirements translate into improved patient care and quality in their practices.

• Uncertainty about how to implement. What do practices want to be measured on? How to measure and integrate into office workflow? How to do claims-based filing, participate in registries, attestation?

• Investment costs vs. returns. Concern over the cost of investing to succeed under QPP, and frustration that “QPP investment” doesn’t necessarily mean better patient care

• Wide range of needs across physician practice types and specialties

• Leveraging incentives/managing risks. Uncertainty on incentive side and concerns about measurement that accounts for risk

• Sustainability of small practices. The current environment under QPP makes it difficult for small and rural practices to thrive

• Limited APM participation options. In some markets, this may define possible pathways for physicians

• EMR vendors adding to confusion, seen as part of the problem

• Lack of interest and engagement. Physicians who don’t understand the complexity are considering opting out of Medicare, retiring in two years, or just taking the hit of the penalty

• Patients. Perceived absence of greater flexibility to engage patients under Medicare rules....
Practical challenges with measurement and reporting

Benchmarks and relative scale
• Benchmarks and the performance threshold change annually and are “budget neutral” – the amount of payment adjustments are uncertain
• Physicians do not know how they compare to peers
• No benchmarks for new measures (so they receive less weight)

Availability and relevance of quality measures
• The availability of applicable and relevant measures varies depending on a physician’s specialty
• The measures used for the cost category are hospital-focused; often viewed as inappropriate for assessing physician performance
• Both outcome and process performance measures may be affected by differences in patient demographics

Continuity and problems with previous reporting programs
• Many physicians submitted their data but did not review their QRURs to assess/improve their performance
• Difficulty in accessing and understanding QRURs, and CMS’s scoring methodology
• Also – reporting requirements have changed from the previous programs, which will cause confusion

Reporting submission process and errors
• Lack of real-time feedback to correct reporting errors – notification of incorrect submissions occurs months after the end of the reporting period
• Vendors – concern over accountability for reporting errors due to incorrect submissions
• Costs associated with multiple data submission methods/vendors with no guarantee in a positive return on investment
Merit-based Incentive Payment System (MIPS)

2017 transition year minimum reporting options
2017 “Transition Year” – Opportunities for easy participation

Don’t Participate
• Submit no data
• -4% payment adjustment in 2019

Test – Submit Something
• Submit a minimum amount of data
• Avoid negative payment adjustment

Partial – Submit Partial Year
• Submit 90-days worth of data
• Avoid negative payment adjustment
• Eligible for maximum positive payment adjustment

Full – Submit Full Year
• Submit data for all 2017
• Avoid negative payment adjustment
• Eligible for maximum positive payment adjustment

A negative payment adjustment can be avoided by reporting just a minimum amount of data!
Options for minimal “test” participation in 2017

Submit something – avoid a -4% payment adjustment with a minimum amount of data

Three options:

• Quality – report data for 1 patient for 1 quality measure (can be reported through claims),
  • Practice Tip: It is recommended that additional data (more than 1 patient) be reported for the quality category to better ensure that the penalty is avoided
• OR Improvement Activities – report 1 improvement activity (can be completed through attestation),
• OR Advancing Care Information – report the required base measures (4 or 5 based on 2014 or 2015 certified EHR technology) for at least 1 patient for each measure

Other approaches - With both the partial (90-day) and full-year participation options, physicians are eligible to receive the maximum positive payment adjustment for reporting the full requirements for each category, if the number of cases is sufficient to be scored
Pathway 1: Merit-based Incentive Payment System (MIPS)

Exemptions and reporting options
# MIPS performance categories - overview

<table>
<thead>
<tr>
<th>Quality</th>
<th>Cost</th>
</tr>
</thead>
</table>
| • Builds off Physician Quality Reporting System  
• Report 6 measures, including 1 outcomes measure or a specialty-specific measures set  
• Primary factor early on -- 60% of score for 2019 payment adjustment | • Builds off Value-based Modifier  
• New cost measures being developed for 2018  
• No data reported; CMS uses administrative claims data to assess performance  
• Implementation eased as costs are 0% of score for 2019 payment adjustment |

<table>
<thead>
<tr>
<th>Advancing Care Information</th>
<th>Improvement Activities</th>
</tr>
</thead>
</table>
| • Builds off Meaningful Use and encourages greater use of health information technology  
• Report required 4 or 5 measures for base score  
• 25% of score for 2019 payment adjustment  
• Challenging area for many physicians | • New category  
• Rewarding engagement in clinical practice improvement activities  
• Report any combination of high and medium weight activities to achieve 40 total points  
• 15% of score for 2019 payment adjustment |
Who does QPP affect and who is required to participate in MIPS?

• The program will eventually include almost all clinicians who bill for Medicare Part B services; this will be phased in over time

• “Eligible Clinicians” subject to MIPS in 2017:
  • Physicians
    • Physician means doctor of: medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, optometry, and, with respect to certain specified treatment, doctor of chiropractic legally authorized to practice by a State in which he/she performs this function
  • Physician Assistants
  • Nurse Practitioners
  • Clinical Nurse Specialists
  • Certified Registered Nurse Anesthetists

• “Eligible Clinicians” may be expanded in 2019 to also include:
  • Physical or occupational therapists
  • Speech language pathologists
  • Audiologists
  • Nurse midwives
  • Clinical social workers
  • Clinical psychologists
  • Dieticians or nutrition professionals
Some eligible clinicians are exempt from MIPS.

Exempted from MIPS

- Newly-enrolled Medicare physicians, who enroll in Medicare for the first time during the performance year
- Physicians and groups that are below the low-volume threshold:
  - Who have Medicare Part B allowed charges ≤ $30,000
  - OR
  - Who provide care to 100 or fewer Medicare Part B patients
- Physicians who are participating in Advanced APMs

CMS estimates - CMS estimates that 32.5% of eligible clinicians will be exempt from MIPS in 2017 because of the low-volume threshold

CMS will make available an NPI-level lookup tool on its QPP website later this year to assist physicians and other clinicians in determining if they are below the low-volume threshold, and therefore excluded from MIPS participation in 2017

- Practice Tip: Physicians should keep a record of the eligibility/exemption status provided by CMS
Participation options for physicians

• Physicians can participate either as individuals or as a group, but they must participate the same way across all four categories

• As an individual
  • Physicians would report under an NPI number and the tax identification number (TIN) of the practice to which they reassign their benefits

• As a group
  • 2 or more physicians (2 or more NPIs) who are part of the same practice with the same TIN
  • Specific reporting requirements and certain reporting options are available for groups of 25 or more physicians
  • All physicians in the group would receive the same aggregated scoring and corresponding payment adjustment across the group

• Additionally, all physicians in a practice must participate the same way – either individually, or as a group
  • For example, in a practice of 10 physicians all under the same TIN, the practice can elect to participate at the group level (the group of 10 physicians would collectively have to meet the specific requirements for each category) or decide that each of the 10 physicians would report as individual physicians (each physician would have to meet the specific requirements for each category)
## Reporting mechanisms and options

<table>
<thead>
<tr>
<th>Category</th>
<th>Reporting Options</th>
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<tbody>
<tr>
<td><strong>Quality</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>Claims, QCDR, Qualified Registry, EHR</td>
</tr>
<tr>
<td>Group</td>
<td>QCDR, Qualified Registry, EHR, CMS Web Interface (groups of 25 or more eligible clinicians), CMS-approved survey vendor for CAHPS (used in conjunction with another reporting mechanism), Administrative Claims</td>
</tr>
<tr>
<td><strong>Improvement Activities &amp; Advancing Care Information</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>Attestation, QCDR, Qualified Registry, EHR</td>
</tr>
<tr>
<td>Group</td>
<td>Attestation, QCDR, Qualified Registry, EHR, CMS Web Interface (groups of 25 or more eligible clinicians)</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>No submission required. CMS will use administrative claims data.</td>
</tr>
<tr>
<td>Group</td>
<td></td>
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</tbody>
</table>
Selecting the best option...

<table>
<thead>
<tr>
<th>Reporting Mechanism</th>
<th>Pros/Cons</th>
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</table>
| Claims                      | The affordable option  
Share responsibility with billing companies  
Confusion and inaccurate reporting of codes for the quality measures  
Not available for all categories (only available for individuals for the quality category) |
| Attestation                 | No submission of data is required; another affordable option  
Must keep records for audit purposes |
| QCDR/Qualified Registry     | These can be specialty-specific and offer more applicable quality measures; but also may be more limited in scope  
Physicians must pay a registration fee and additional fees for data integration services; however, some national specialty societies offer this option at no or low cost to members  
Difficulty linking to EHR systems and automatically extracting the data (often requires manual data entry)  
Requirement for “all-payer data” |
| EHR                         | Many practices already use EHRs in daily practice (but not all practices have access to EHRs)  
Vendor submits the data on your behalf, but you must trust that vendor will correctly and accurately submit the information  
Depending on the measures selected and number of applicable patients, may be more advantageous to use an EHR than a specialized registry  
Limited availability of applicable quality measures that can be reported via an EHR |
| CMS Web Interface           | Only for groups of 25 or more physicians and eligible clinicians  
Higher reporting thresholds for Quality measures (must report more measures)  
Must register by June 30, 2017 |
| CAHPS                       | Must register by June 30, 2017  
Must be reported in conjunction with another reporting mechanism |
| Administrative Claims       | No submission is required  
Uncertainty about your performance and how CMS will use the data in its calculations |
Pathway 1: Merit-based Incentive Payment System (MIPS)

Overview of approach to performance measurement and payment incentives
MIPS – the essentials

• Combines current quality reporting and value-based programs into one program

• MIPS comprised of four categories:
  • **Quality** – builds off the current Physician Quality Reporting System (PQRS) program
  • **Advancing Care Information** – next phase of EHR Incentive Program (Meaningful Use)
  • **Cost** – based on the Value-based Payment Modifier (VM)
  • **Improvement Activities** – new category that rewards physicians for activities that improve the clinical practice and delivery of care

• MIPS participating physicians get a MIPS final score based on their total combined, weighted average score across all categories

• CMS will compare score to an overall performance threshold and then determine positive, neutral, or negative payment adjustments

• Payment adjustments must be budget neutral across all payments to physicians in program
  • There will be no winners without losers
MIPS – details on performance scores and payment adjustments

• Physicians receive a score for each of the 4 performance categories
  • 2017 scores will be based on 3 performance categories (quality, improvement activities, and advancing care information)
  • 2018 onwards, scores will be based on all 4 performance categories (including cost)

• Weights apply to each category to get to a final score out of 100 points

• CMS will publish a minimum threshold of points out of 100 that physicians must achieve in their MIPS final score to avoid a negative payment adjustment

  • For 2017, the threshold for avoiding a negative payment adjustment is only 3/100 total points – this can be achieved by reporting at least 1 quality measure or improvement activity
  • For 2018 onwards, CMS will make threshold determinations using mean or median final scores from a prior period

Example (using 2018 performance year category weights):

\[
(\text{quality score } \% \times 50\%)(100) + (\text{cost score } \% \times 10\%)(100) + (\text{improvement activities score } \% \times 15\%)(100) + \\
(\text{advancing care information score } \% \times 25\%)(100) > \text{threshold to avoid a negative payment adjustment}
\]
Extra bonus payments available for high MIPS performers

Up to $500 million available in aggregate across the program for each year 2019 – 2024

The top 25% of performers above the performance threshold will receive at least a 0.5%, but up to a 10%, bonus payment for exceptional performance

Physicians with a final score that is ≤ 25% of the threshold will receive the maximum negative payment adjustment each year 2019 (-4%) – 2024 (-9%)

Scores less than 25% of the performance threshold

The threshold for the exceptional performance payment adjustment for the 2017 performance year/2019 payment year is 70 points.
MIPS category weights behind final score calculation - and how they change over time

2017 - Category Weights

- Quality: 60%
- ACI: 25%
- Improvement Activities: 15%

2018 - Category Weights

- Quality: 50%
- ACI: 25%
- Improvement Activities: 15%
- Cost: 10%

These are default weights that may be adjusted in certain circumstances.
Final score in 2019 and beyond – cost becomes more important

These are default weights that may be adjusted in certain circumstances.
### Performance to payment timeline – submission and CMS dates for 2017 performance year

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
<th>Details</th>
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<tbody>
<tr>
<td>Performance period began</td>
<td>Jan 1, 2017</td>
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<tr>
<td>• Registration deadline for CMS Web Interface and CAHPS</td>
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<tr>
<td>• CMS review of APM Participation List</td>
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<tr>
<td>• CMS publishes 2017 QCDRs</td>
<td>March/Spring 2017</td>
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<tr>
<td>• CMS review of APM Participation List</td>
<td>June 30, 2017</td>
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<tr>
<td>• Last day to begin 90-day reporting period</td>
<td>Aug 31, 2017</td>
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<tr>
<td>• CMS review of APM Participation List</td>
<td>Oct 2, 2017</td>
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<tr>
<td>• Last day 2017 claims processed for 2019 adjustment</td>
<td>Dec 31, 2017</td>
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<tr>
<td>• Last day 2017 claims processed for 2019 adjustment</td>
<td>Late Feb. 2018</td>
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<tr>
<td>• CMS review of APM Participation List</td>
<td>March 31, 2018</td>
<td></td>
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<tr>
<td>• 2017 data submission deadline for QCDRs, qualified registries, EHRs, CMS Web Interface, attestation</td>
<td>Fall 2018</td>
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<tr>
<td>• CMS applies adjustment based on 2017 performance</td>
<td>Jan 2019</td>
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<tr>
<td>• CMS feedback reports on 2017 performance and targeted review period to appeal errors</td>
<td></td>
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<tr>
<td>• CMS applies adjustment based on 2017 performance</td>
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- **Late Feb. 2018**
  - Last day 2017 claims processed for 2019 adjustment
- **March 31, 2018**
  - 2017 data submission deadline for QCDRs, qualified registries, EHRs, CMS Web Interface, attestation
- **Fall 2018**
  - CMS feedback reports on 2017 performance and targeted review period to appeal errors
- **Jan. 2019**
  - CMS applies adjustment based on 2017 performance
Next steps and looking forward
Next Steps: Should I select the MIPS pathway?

1. Determine whether you are exempt from MIPS participation
2. Pick your quality reporting pace for 2017 by evaluating practice readiness
3. Select the best reporting mechanism(s) by evaluating practice resources
   - Is a specialty-, diagnosis-, or treatment-specific QCDR with more applicable measures available?
   - What new processes and workflows will need to be put in place to meet the reporting requirements?
   - Do you have access to an EHR?
4. Consider whether the Advanced APM option is feasible before making the final decision

If you aren’t participating in an Advanced APM:
   - Review the quality category measures and improvement activities and select at least one measure or activity to avoid the negative payment adjustment
   - Determine if participating for a minimum of 90 days and becoming eligible to receive a positive payment adjustment is feasible for you/your practice
   - Review current 2017 and proposed 2018 Advanced APMs and determine if participating in the APM track is an option for the future

If you are participating in an Advanced APM:
   - CMS will make 3 evaluations in 2017 to determine whether physicians meet QP/PQ thresholds
     - The determination periods are March 31 (decision by July 2017), June 30 (decision by October 31), and August 31 (decision by December 31)
     - Check these determinations to see if you have meet the QP/PQ thresholds and are exempt from MIPS
What PAI-Healthsperien resources will be available to help?

• **Follow-on products in 2017** – In-depth one-pagers and monographs focused on topics such as the MIPS scoring system and strategies for reporting and how to meet the minimum reporting requirements for 2017

• **In development** – Guide to additional resources in physician communities

• **FAQ document** – updated on a continuous and ongoing basis with important questions

• **Regular e-mail updates** – Emails will provide updates on new information, materials, and tools available from PAI, Healthsperien, as well as CMS and other organizations
www.PhysiciansAdvocacyInstitute.org