Molly MacHarris
Program Lead, MIPS
Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services

Topics

- What is the Quality Payment Program?
- Who participates?
- How does the Quality Payment Program work?
- Where can I go to learn more?

What is the Quality Payment Program?

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

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)

The Quality Payment Program

- The Quality Payment Program policy will reform Medicare Part B payments for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care delivery system.
- Clinicians can choose how they want to participate in the Quality Payment Program based on their practice size, specialty, location, or patient population.

Two tracks to choose from:

Advanced Alternative Payment Models (APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

or

The Merit-based Incentive Payment System (MIPS)

If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

Who participates?

Who participates in MIPS?

- Medicare Part B clinicians billing more than $30,000 a year **and** providing care for more than 100 Medicare patients a year.
- These clinicians include:
  - Physicians
  - Physician Assistants
  - Nurse Practitioners
  - Clinical Nurse Specialists
  - Certified Registered Nurse Anesthetists

Who is excluded from MIPS?

- **Newly-enrolled Medicare clinicians**
  - Clinicians who enroll in Medicare for the first time during a performance period are exempt from reporting on measures and activities for MIPS until the following performance year.
- **Clinicians below the low-volume threshold**
  - Medicare Part B allowed charges less than or equal to $30,000 **OR** 100 or fewer Medicare Part B patients
- **Clinicians significantly participating in Advanced APMs**

Easier Access for Small Practices

Small practices will be able to successfully participate in the Quality Payment Program

Why?

- Reducing the time and cost to participate
- Providing an on-ramp to participating through Pick Your Pace
- Increasing the opportunities to participate in Advanced APMs
- Including a practice-based option for participation in Advanced APMs as an alternative to total cost-based
- Conducting technical support and outreach to small practices through the forthcoming QPP Small, Rural and Underserved Support (QPP-SURS) as well as through the Transforming Clinical Practice Initiative.

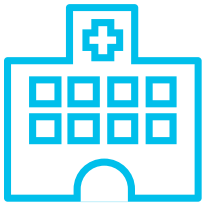
Small, Rural and Health Professional Shortage Areas (HPSAs) Exceptions

- Established low-volume threshold
  - Less than or equal to $30,000 in Medicare Part B allowed charges or less than or equal to 100 Medicare patients
- Reduced requirements for Improvement Activities performance category
  - One high-weighted activity or
  - Two medium-weighted activities
- Increased ability for clinicians practicing at Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) to qualify as a Qualifying APM Participant (QP).

How does the Quality Payment Program work?

Pick Your Pace for Participation for the Transitional Year

Participate in an Advanced Alternative Payment Model



- Some practices may choose to participate in an Advanced Alternative Payment Model in 2017

MIPS

Test Pace

Submit Something

- Submit **some** data after January 1, 2017
- Neutral or small payment adjustment

Partial Year

Submit a Partial Year

- Report for 90-day period after January 1, 2017
- Small positive payment adjustment

Full Year

Submit a Full Year

- Fully participate starting January 1, 2017
- Modest positive payment adjustment

Not participating in the Quality Payment Program for the transition year will result in a negative 4% payment adjustment.

MIPS: Choosing to Test for 2017

- If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity), you can avoid a downward adjustment

MIPS: Partial Participation for 2017

- If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.
- That means if you're not ready on January 1, you can choose to start anytime between January 1 and October 2, 2017. Whenever you choose to start, you'll need to send in performance data by March 31, 2018.

MIPS: Full Participation for 2017

- If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment. The best way to earn the largest positive adjustment is to participate fully in the program by submitting information in all the MIPS performance categories.

Key Takeaway:

- Positive adjustments are based on the performance data on the performance information submitted, not the **amount** of information or **length of time submitted.**

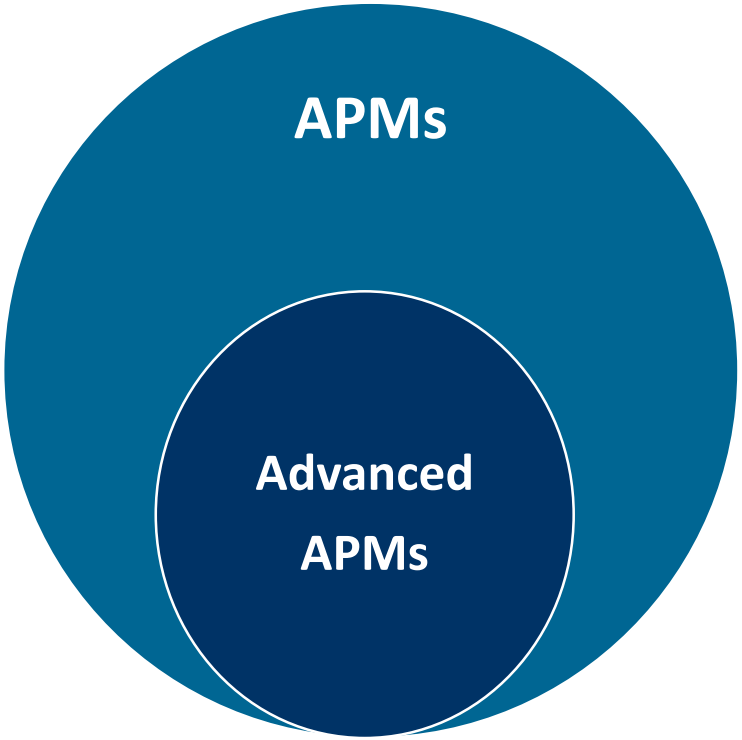
Bonus Payments and Reporting Periods

- MIPS payment adjustment is based on data submitted.
- Best way to get the max adjustment is to participate for a full year.
- A full year gives you the most measures to pick from. **BUT** if you report for 90 days, you could still earn the max adjustment.
- We're encouraging clinicians to pick what's best for their practice. A full year report will prepare you most for the future of the program.

Alternative Payment Models

- An Alternative Payment Model (APM) is a payment approach, developed in partnership with the clinician community, that provides added incentives to clinicians to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.
- APMs may offer significant opportunities to eligible clinicians who are not immediately able or prepared to take on the additional risk and requirements of Advanced APMs.

Advanced APMs are a Subset of APMs



Advanced Alternative Payment Models

- Advanced Alternative Payment Models (Advanced APMs) enable clinicians and practices to earn greater rewards for taking on some risk related to their patients' outcomes.
- It is important to understand that the Quality Payment Program does not change the design of any particular APM. Instead, it creates **extra incentives** for a sufficient degree of participation in Advanced APMs.

Advanced APMs
Advanced APM-specific rewards + 5% lump sum incentive

Advanced APMs in 2017

For the **2017 performance year**, the following models are Advanced APMs:

Comprehensive End Stage Renal Disease Care Model (Two-Sided Risk Arrangements)	Comprehensive Primary Care Plus (CPC+)
Shared Savings Program Track 2	Shared Savings Program Track 3
Next Generation ACO Model	Oncology Care Model (Two-Sided Risk Arrangement)

The list of Advanced APMs is posted at QPP.CMS.GOV and will be updated with new announcements on an ad hoc basis.

Future Advanced APM Opportunities

- MACRA established the **Physician-Focused Payment Model Technical Advisory Committee (PTAC)** to review and assess Physician-Focused Payment Models based on proposals submitted by stakeholders to the committee.
- **In future performance years**, we anticipate that the following models will be Advanced APMs:

Comprehensive Care for Joint Replacement (CJR) Payment Model (CEHRT)

New Voluntary Bundled Payment Model

Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT)

Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

ACO Track 1+

Where can I go to learn more?

The Quality Payment Program Service Center is also available to help:

qpp.cms.gov

CMS has organizations on the ground to provide help to clinicians who are eligible for the Quality Payment Program:

TCPI

Transforming Clinical Practice Initiative (TCPI): TCPI is designed to support more than 140,000 clinician practices over the next 4 years in sharing, adapting, and further developing their comprehensive quality improvement strategies. Clinicians participating in TCPI will have the advantage of learning about MIPS and how to move toward participating in Advanced APMs. Click here to find help in your area.

QIN-QIOs

Quality Innovation Network (QIN)-Quality Improvement Organizations (QIOs): The QIO Program's 14 QIN-QIOs bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality. More information about QIN-QIOs can be found here.

APM Learning Systems

If you're in an APM: The Innovation Center's Learning Systems can help you find specialized information about what you need to do to be successful in the Advanced APM track. If you're in an APM that is not an Advanced APM, then the Learning Systems can help you understand the special benefits you have through your APM that will help you be successful in MIPS. More information about the Learning Systems is available through your model's support inbox.

When and where do I submit comments?

- The **final rule with comment** includes changes not reviewed in this presentation. We will not consider feedback during the call as formal comments on the rule. See the proposed rule for information on submitting these comments by the close of the **60-day comment period** on **December 19, 2016**. When commenting refer to file code **CMS-5517-FC**.
- Instructions for submitting comments can be found in the proposed rule; FAX transmissions will not be accepted. You must officially submit your comments in one of the following ways: electronically through
  - Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier
- **For additional information, please go to: QPP.CMS.GOV**


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Do you need technical assistance to help you participate in the Quality Payment Program? The Centers for Medicare & Medicaid Services has specialized programs and resources for eligible clinicians across the country.

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.

Locate the PTN(s) and SAN(s) in your state

SMALL & SOLO PRACTICES

Small, Underserved Rural Support Technical Assistance

- Provides outreach, guidance, and direct technical assistance to clinicians in solo or small practices (15 or fewer), particularly those in rural and underserved areas, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - Organizations selected to provide this technical assistance will be available in late 2016.

LARGE PRACTICES

Quality Innovation Network-Quality Improvement Organizations (QIN-QIO) Education and Support

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit- Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Advanced Alternative Payment Model (APM) Learning Networks
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs.

“If You Can’t Measure It, You Can’t Manage It”

The Misquote That Launched 1000 Ships – or at Least MACRA Legislation

Robert Berenson M.D.

Institute Fellow, Urban Institute

rberenson@urban.org

“If you can’t measure it, you can’t manage it”

- And its close cousin, “If something… cannot be measured, it cannot be improved.”
- Called a truism, the quote is commonly attributed to W. Edwards Deming, now deceased, a widely revered expert in management and management science

What Deming actually wrote

- "It is wrong to suppose that *if you can't measure it, you can't manage it* – a costly myth."
  - *The New Economics*, 1994, page 35.
  - So not just taken out of context, but an overt, (intentional?) misquote
- Other consistent Deming quotes (of many available):
  - "The most important figures one needs for management are unknown or unknowable, but successful management must nevertheless take account of them." *Out of the Crisis*, 1982, p 121
  - "Management by numerical goal is an attempt to manage without knowledge of what to do, and in fact is usually management by fear." *Out of the Crisis*, p. 76

Dueling slogans

- *"If you can't measure it, you can't manage it"*
- *"Not everything that can be counted counts, and not everything that counts can be counted."*
  - Commonly attributed to Albert Einstein, it was actually coined by a sociologist named William Bruce Cameron, writing after Einstein had died

No wonder we don’t do evidence-based policy making

We can’t even get quotes right

Important to distinguish measures for public reporting & P4P and for internal QI

- Of course, for internal process improvement, having data on performance is often highly desirable or even necessary
- For internal QI, one can be less rigorously accurate – reputations are not at stake. Screen and home in
- The different purposes – QI v P4P -- generate very different data sets
- My concern here is the public policy infatuation with public reporting and P4P, not with how organizations use measurement as part of QI efforts to produce reliable processes (what Deming did care about)

The Three Major Problems With P4P (so the MIPS in MACRA)

- Conceptually flawed because of a “crowd out” of intrinsic motivation that professionals have
  - Testing to the test, while overall performance declines?
- Relevant and accurate measurement is difficult and very costly, and some problems won’t be corrected any time soon (despite MACRA’s recognition of substantial measure gaps -- we don’t have the data)
- The accumulating evidence on P4P across more than a dozen OECD countries finds no evidence that P4P in practice meets the “compelling logic” that advocates assert

The food here is terrible -- and such small portions

-- 1920's Catskill's joke

The public understandably does not rely much on ratings based on current measurement

- Four prominent hospital rating programs identified different sets of high performing hospitals – with very few overlaps
  - Explained by the fact that each system uses its own rating methods, has a different focus to its ratings, and stresses different measures – Austin, et al. Health Affairs, Mar. 2015
  - The ratings may have made good sense to the ratings' producers, but what is the public supposed to make of all this?

The current policy infatuation with public reporting and, especially, P4P has lead to this perverse policy result:

What we measure publically is considered important and demanding attention while
What we can't or don't measure is marginalized or ignored altogether -- like diagnosis errors, a major, largely ignored, quality problem

Further, often we can improve quality and value without the difficulty of measurement by redesign of basic, "legacy" payment methods

How to improve the use of measurement in public policy
(from Berenson, Pronovost, and Krumholz)

- Use measures strategically as part of major quality improvement initiatives;
- Measure at the level of the health care system and then the organization, not the clinician (the market will do that);
- Expedite moving from processes to outcomes (not easy);
- Place greater emphasis on patient experience and patient-reported outcome measures – as important in themselves;
- Invest more in the "basic science" of measurement development, tasking a single entity with defining standards for measuring and reporting performance:
  - to improve the validity and comparability of publicly-reported quality data and
  - to anticipate and prevent unintended adverse consequences

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

“Stabilizes” fee updates

- Repeals SGR, averting a nearly 25% cut in fees
- July 2015-2019: Annual fee update 0.5%, 2020-2025 0%
  - Payment increases (and decreases) take place through MIPS
- After 2025: 0.25% update, but 0.75% if APM participation
- Before 2025, 5 percent bonuses for six years for physicians that qualify as participating in APMs with more than “nominal risk”
  - Qualified medical homes count as APMs without risk
  - Participants in APMs get out of the MIPS

The MACRA *Quid Pro Quo* for repeal of the Sustainable Growth Rate

- The actual substantial cost of the not reducing physician fees by >20% was paid for through a long-term schedule of nominal fee increases
- The *quid pro quo* – the concept of moving from payment "volume to value" -- was not primarily about paying for the SGR fix, but rather about aspirationally desirable improvements in delivery
- There are two arms of the strategy – the MIPS and Alternative Payment Models – clinicians are given a choice

The Merit-based Incentive Payment System (MIPS)

- Combines the 3 current incentive programs:
  - Physician Quality Reporting System (PQRS) – quality
  - Value-Based Modifier (VBM) – quality & resource use
  - Meaningful Use (EHR)
- Applies to payments after January 1, 2019 – the current programs are in use till then and sun-setted
- Applies to all the types of health professionals receiving fee schedule $'s
- Excludes those with too few Medicare patients or Medicare revenues and those who have threshold level of payment through alternative payment methods
- May participate through EHR use, qualified clinical data registries and/or through group, "virtual" group or affiliation with a facility or hospital

MIPS assessment categories
(percentages when fully phased in in 2022)

- Quality (30%)
- Resource Use (30%)
- Meaningful Use of EHRs (25%)
- Clinical Practice Improvement Activities (15%)
  - Such as expanding practice areas, population management, care coordination, beneficiary engagement, patient safety

MIPS payment adjustments

- Negative adjustments capped
  - Those at 0-25% of threshold get maximum negative adjustment
    - 2019: 4% --- 2020: 5% --- 2021: 7% --- 2022: 9%
- Positive
  - Maximum: 3 X annual cap for negative adjustment – so theoretically as much as 27% more (I am not kidding)
  - Eligible for additional payment if 25% above performance threshold
    - But total is capped at $500 million / year (2019-2024)

What MACRA got right

- Repealing and paying (sort of) for the SGR repeal
- Combining three separate P4P programs into one (although functionally there now are four categories, each with measures to report)
- Reduced the immediate financial impact of the MIPS with a phase in to the 9% up or down impact
- Including clinical practice improvement as a new component of accountability
- Promoting alternative payment models as the more fundamental objective in the move from volume to value
- Creating the Physician Focused Payment Model Technical Advisory Committee (on which I serve)

What MACRA got wrong

- It is numbingly complex, rewarding providers able to do “game theory,” and threatens survival of small practices
- The timelines are overly ambitious and will lead to flawed adoption of APMs – per capita cost increases in Medicare are as flat as ever, ~ GDP. Where’s the fire?
- The idea that CMS can and should place a rating on a physician’s value reflects Congressional overreach
- Rewarding physicians with an extra 5% and exemption from MIPS for participating in unproved demos doesn’t add up to program savings – requirements for financial risk-taking in the models, notwithstanding
- The complex of public reporting, P4P, and APM exploration diverts attention from other policies and opportunities to improve value that don’t fit into the measurement frame

CMS deserves credit for the Oct.14 final (with comments) MACRA Rules for:

- Exempting nearly 400,000 clinicians, most from small practices, with annual Medicare revenues of <$30,000
- In year one, eliminating the resource cost component of the composite score
- Reducing, focusing and renaming the measurement requirements related to EHR adoption – from Meaningful Use to Advancing Care Information
- Providing a “transition year” for clinicians – effectively postponing the kick-off of data collection by 9 months, if so desired, and let clinicians experience the process
- Buying time so policy makers both in Congress and the new Administration can reconsider what they have wrought

Thanks

Understanding the Interaction between MACRA and Medicare Advantage

Allyson Y. Schwartz
President & CEO
Better Medicare Alliance

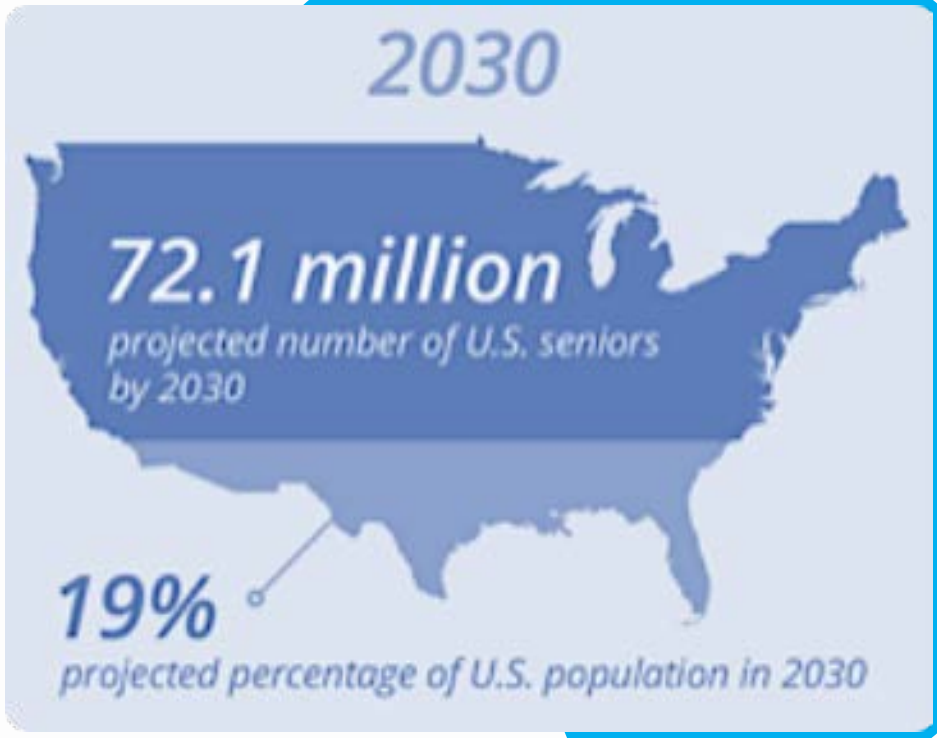
BETTER MEDICARE
ALLIANCE

Better Medicare Alliance is the leading coalition advocating for Medicare Advantage. We are a coalition of 75 ally organizations and over 100,000 beneficiaries representing a wide range of stakeholders, including health plans, providers, health systems, aging service agencies, business groups.

There are 10,000 new seniors every day in this country. From 38.8 million in 2010, the number of Americans aged 65 or older will grow to 88 million in 2050.

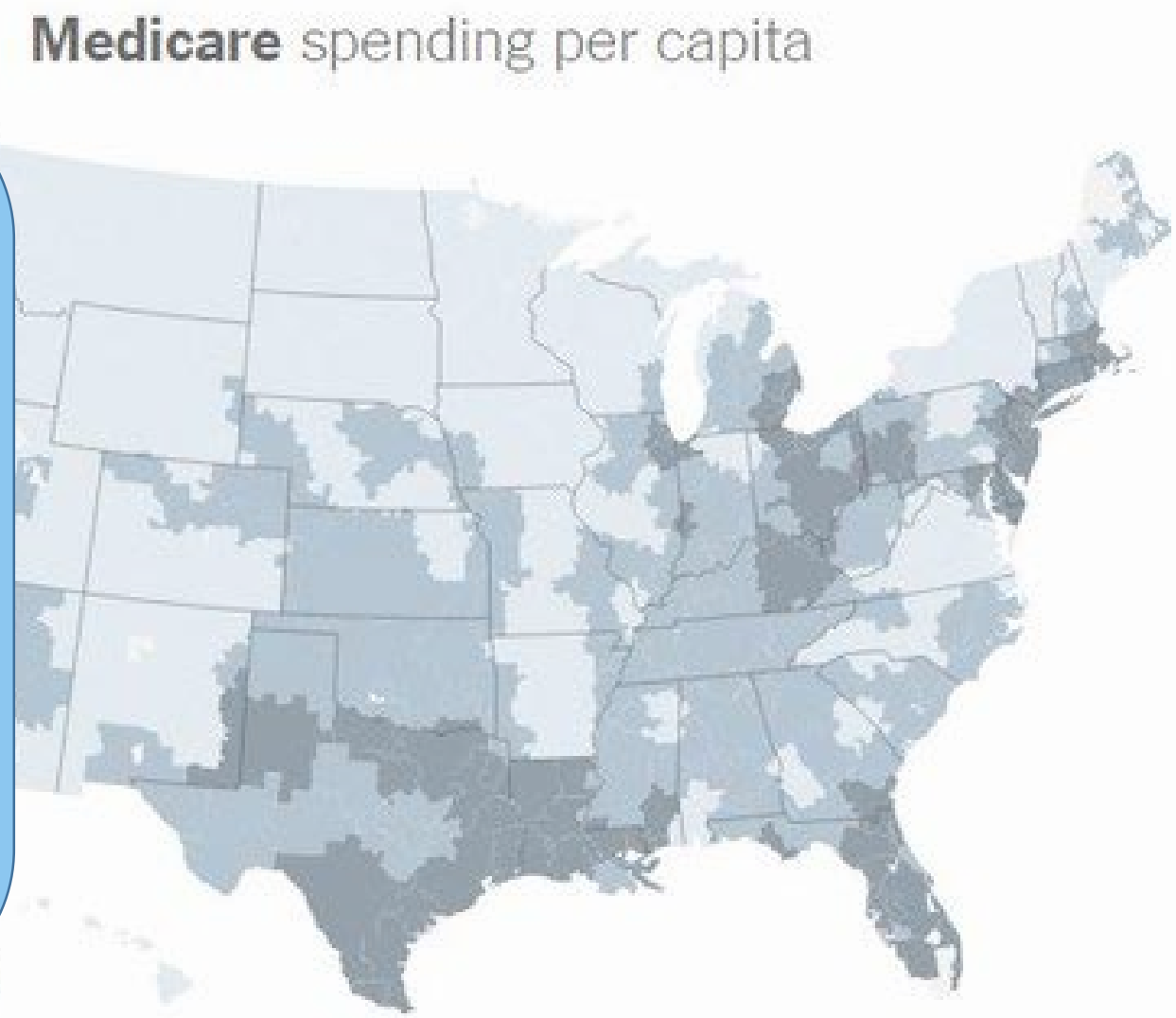
Aging Population

- Over the next 25 years, the number of Americans over 65 will more than double
- From 38.8 million in 2010, the number of Americans aged 65 or older will grow to 88 million in 2050.
- Americans aged 85 and older will grow from 5.2 million in 2010 to 19 million in 2050.



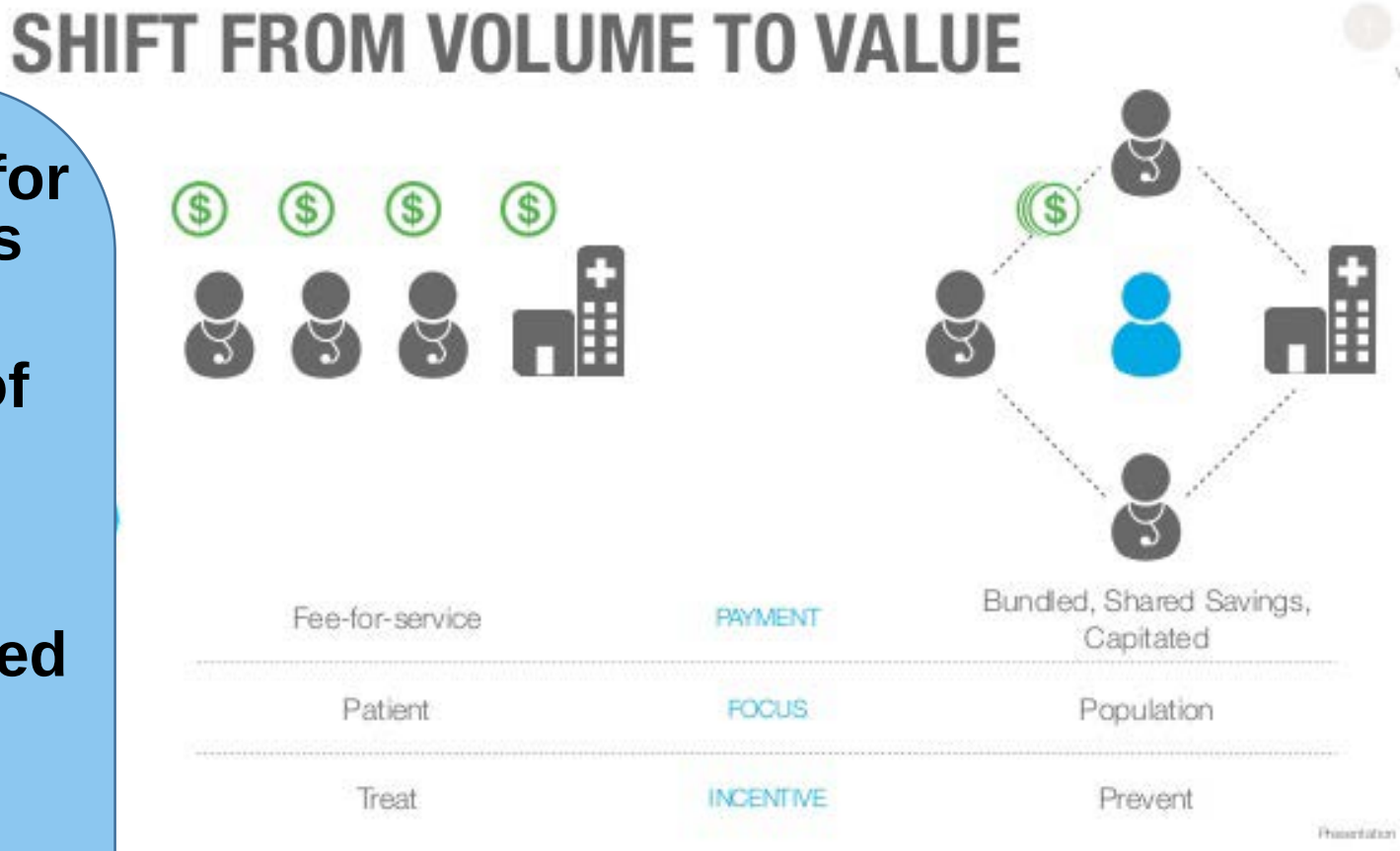
Medicare Spending

- **Of the $3 trillion spent on personal health care in our country in 2014, Medicare accounted for 20 percent, or over $600 billion**
- **Government pays almost 50% of all health care costs in the country - Medicare is the largest single purchaser of health care**
- **Medicare is 14% of the federal budget**
- **Spending is projected to rise from 3.4 percent of GDP in 2015 to 5.4 percent of GDP by 2035**



Fee-For-Service Medicare

- **A model that offers payments for services provided, by hospitals and by doctors.**
- **Designed for short, episodes of acute illness, particularly for unexpected and costly hospitalizations.**
- **Highly disintegrated, fragmented and costly system.**
- **Does not adequately cover efficient and innovative approaches to treatment and care.**



Explaining MACRA

MACRA introduces two payment tracks under FFS Medicare.

- **One payment track – MIPS - expands pay-for-performance incentives within the fee-for-service system**.
- The **second track in MACRA** is intended to be more significant change in FFS payments. **Under these rules, there are 2 options: APMs and advanced APMs.**
- To qualify as an APM, the provider must use Certified EHR Technology, report on a number of quality measures, and bear financial risk.
- The final MACRA rule does not directly include Medicare Advantage.
- However, CMS is expected to use Medicare Advantage arrangements as a way for providers to qualify for the bonus payment in the proposed regulation beginning in 2021.

Medicare Advantage Transforming Medicare

Medicare Advantage (MA) provides seniors with the choice of obtaining their Medicare benefits from a private plan.

Medicare Advantage

- ✓ Highly accountable and carefully regulated
- ✓ Risk based, payment structure based on being at or below Fee-for-Service Medicare per capita costs
- ✓ Mandated quality reports and rewards for high quality
- ✓ Consumer protections for out of pocket costs
- ✓ Opportunity for costs savings to be reinvested in innovations or enhanced benefits for enrollees.

APMs and Medicare Advantage

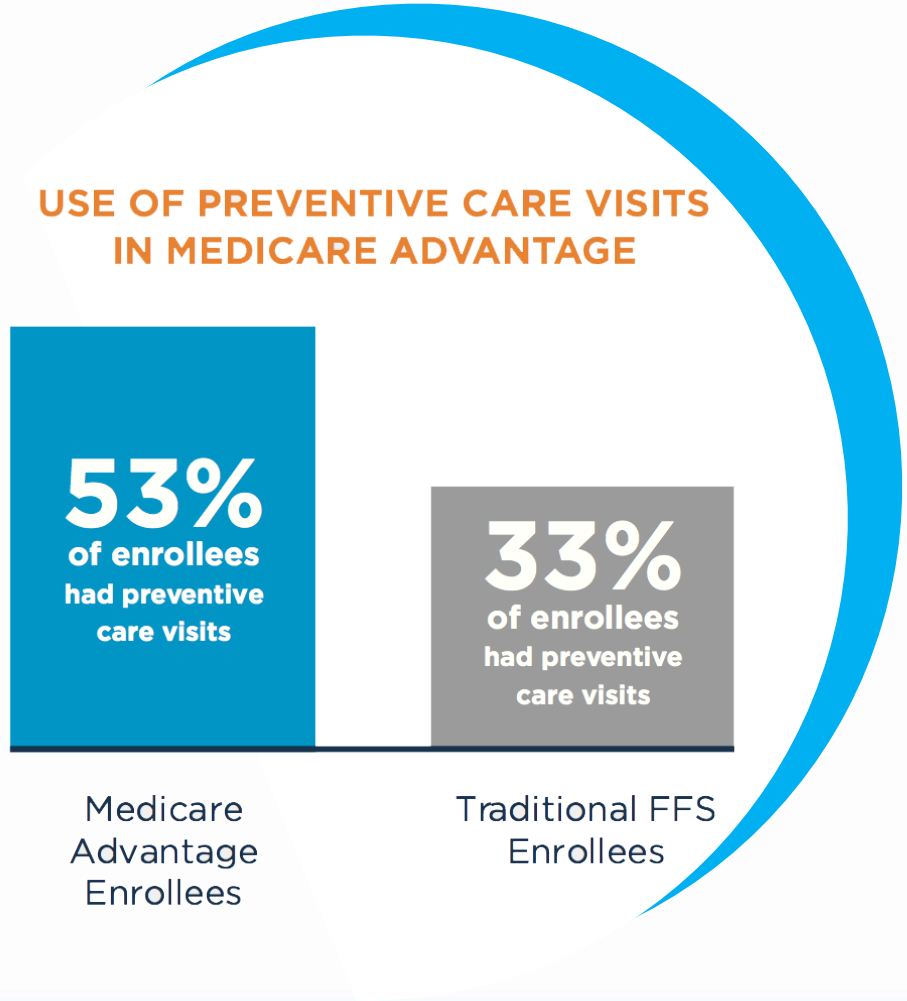
- **Change the "cut-points"** to align with the timing of provider payment agreements to enable these agreements to offer incentives prospectively rather than after the fact.
- **Lift the cap on benchmark payments** to ensure there are incentives in the Stars program for plans and providers to keep moving towards the goal of improving quality.
- Work to better ensure quality and performance reporting is aligned between FFS and Medicare Advantage, to **ease the reporting burdens on providers** and ensure that MA is not disadvantaged in any way.
- **Tweak the bonus payments to plans to incentivize more arrangements.**
- **Continuing the flexibility plans now have to tailor agreements with providers in MA.**

Medicare Advantage & Value Based Care

- Medicare Advantage plans are changing their payment agreements with provider groups to move service deliver from volume to value.
- Medicare Advantage plans are expanding value-based, risk assumption provider agreements to reward high value care.
- Aetna has set a goal to reach **75%** of its medical spending in Medicare Advantage to value-based contracting by 2020.
- Humana aims to have **75%** of its Medicare Advantage enrollees in value-based care models by 2017.
- United Healthcare expects value-based care arrangements for its enrollees to reach $65 billion by the end of 2018.

Medicare Advantage Success

- MA beneficiaries are **20% more likely** to have an annual preventive care visit compared to Traditional Medicare.
- Emergency room visits are 20% to 25% lower among Medicare Advantage enrollees and inpatient medical days are 25% to 35% lower.
- Outpatient surgery and procedure use are also lower.



For more information:
visit bettermedicarealliance.org

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