**MACRA, MIPS and APMs:  
Exploring the new   
Quality Payment Program  
 *PowerPoint***

***Converted to Word Doc***

**QUALITY PAYMENT PROGRAM OVERVIEW VIDEO**

**Slide 1**

**MACRA What is it?**

* **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)**
* **Bipartisan legislation that replaced the flawed Sustainable Growth Rate (SGR) formula by paying clinicians for the value and quality of care they provide**
* **MACRA is more predictable than SGR. It will increase the number of physicians participating in alternative payment models (APMs), with those in high quality, efficient practices benefiting financially**
* **Extends funding for Children’s Health Insurance Program (CHIP) for two years**
* **And introduces us to…**

**SCRIPT**

MACRA is the acronym for the Medicare Access and CHIP Reauthorization Act of 2015, otherwise known as the "Doc Fix" bill. This bipartisan legislation replaced the flawed SGR or Sustainable Growth Rate, which had it gone into effect, would have significantly reduced Medicare provider payments. The SGR is thankfully gone and beginning in 2017 is now replaced with this much more predictable program called MACRA. MACRA will increase the number of physicians who are participating in something called Alternative Payment Models or APMs...which will be discussed in more detail later...with those in high quality, efficient practices receiving significant financial benefits. There are MANY legislative changes included in MACRA, and as the name would suggest, it extends the funding for the Children’s Health Insurance Program for an additional two years. The main thing it brings to us, and what we'll be discussing today, is the Quality Payment Program.

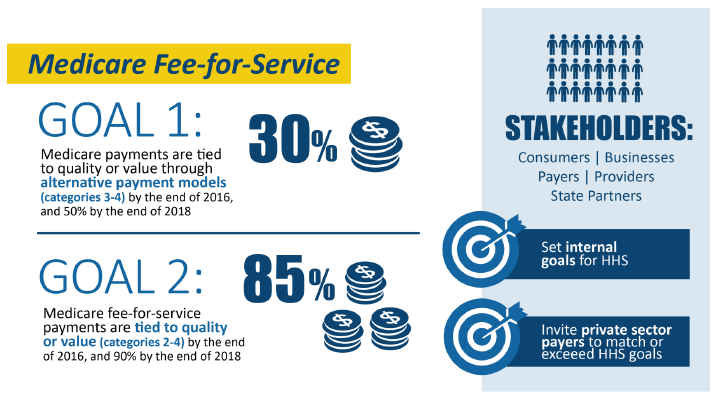
**Slide 2**

**The Quality Payment Program**

**Part of a broader push towards paying for VALUE and QUALITY**

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(Note: CMS has several versions of the QPP logo if we want to use something else instead)

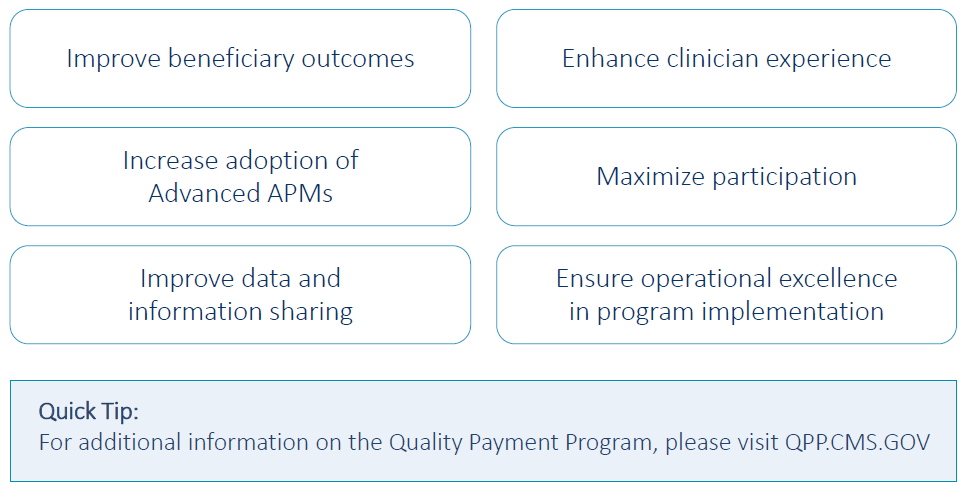
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**SCRIPT**

The Quality Payment Program or QPP is part of a broader push towards paying for value and quality. For Medicare Part B, it's no longer a sheer numbers game where the more claims providers submit, the more revenue that’s generated. Controlling costs and increasing the quality of care delivered are now important factors that must be addressed simply to maintain current Medicare reimbursement levels. There are some embedded goals attached to this program, goal one being 30% of all Medicare payments tied to quality or value through Alternative Payment Models by the end of 2016 and 50% by the end of 2018. Goal 2 is to have 85% of Medicare Fee-for-Service payments tied to quality or value by the end of 2016 and 90% by the end of 2018. CMS reports that they are well on their way to meeting and even exceeding these goals. For now, this program only affects Medicare Part B claims, but over time we should see the private sector launch similar programs to the Quality Payment Program.

**Slide 3**

**Quality Payment Program Strategic Goals**

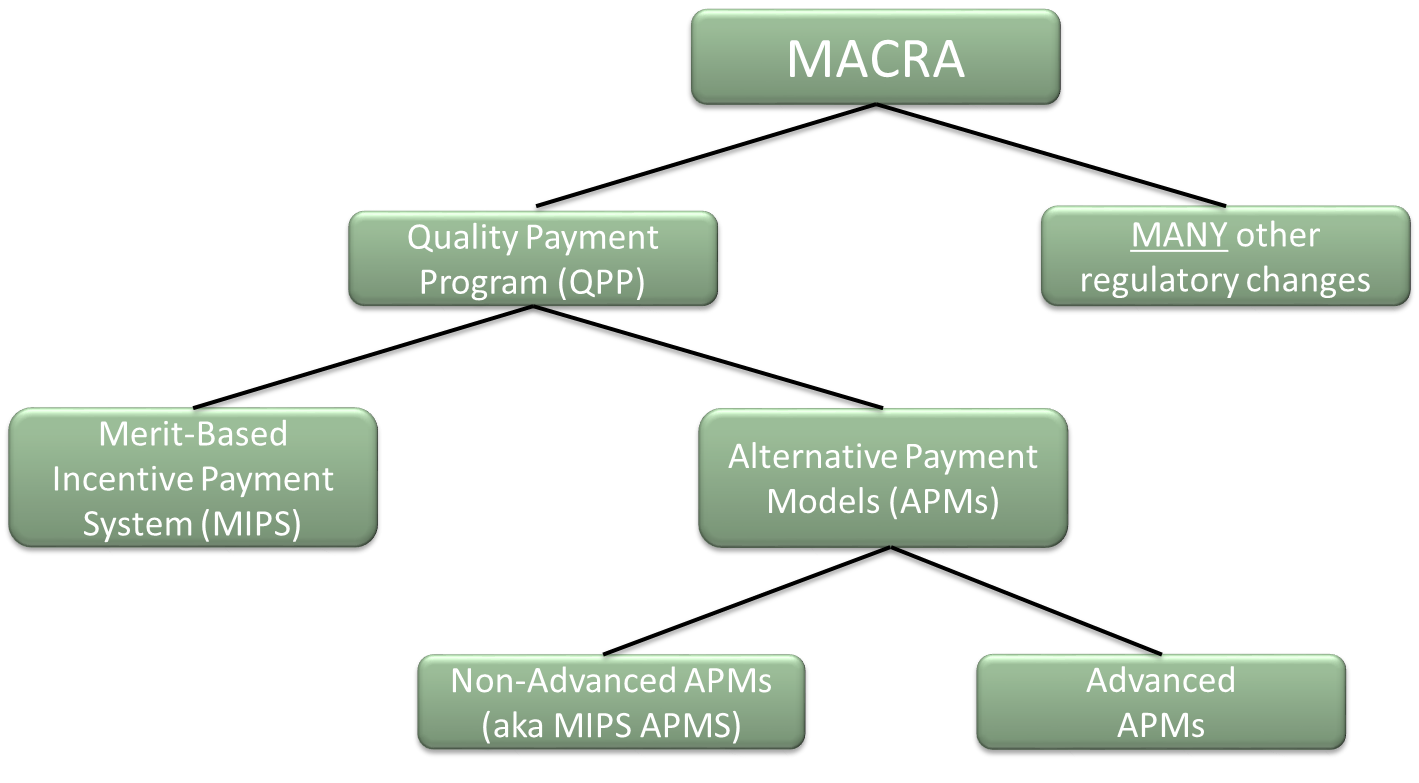
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**SCRIPT**

There are several strategic goals for the QPP: improving beneficiary outcomes, enhancing the clinician experience, increasing the adoption of Advanced Alternative Payment Models, maximizing participation, improving data and information sharing, and ensuring the operational excellence in program implementation. For additional information on the Quality Payment Program, please visit QPP.CMS.GOV, a great, comprehensive site for QPP program information and helpful tools.

**Slide 4**

**Conceptual MACRA Diagram**



**SCRIPT**

This conceptual diagram of MACRA can assist in your understanding of this complex program and the components of it being discussed today. At the very top, we have MACRA, the overarching legislation. There are many regulatory changes contained within MACRA, but today we are only discussing a small portion of it. A main component of MACRA is the QPP, or the Quality Payment Program. Within the QPP there are two paths for participation, one is MIPS, or the Merit-Based Incentive Payment System, and the other path is APMs, or Alternative Payment Models. There are two types of APMs that are relevant to the Quality Payment Program, Non-Advanced APMs, otherwise referred to in this program as MIPS APMs, and Advanced APMs. The long term goal of the program is to get as many providers as possible participating in Advanced APMs. Initially, the majority of participants are going to be participating in path one, the MIPS path, and over time, we will see the number of MIPS participants shrink as they make the transition to participate in track two of the QPP, Alternative Payment Models.

**Slide 5**

**Path 1:   
Merit-based Incentive Payment System   
(MIPS)**



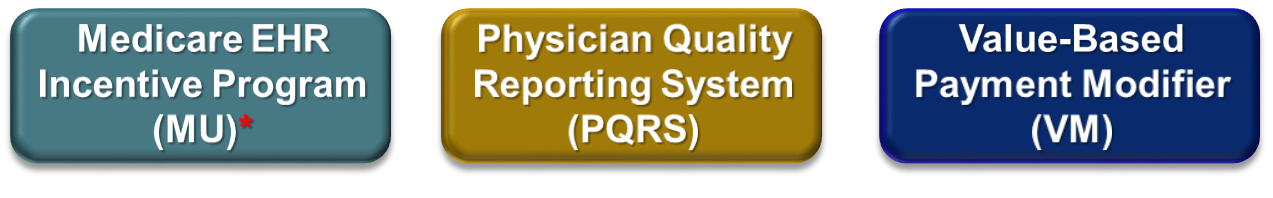
**SCRIPT**

Let’s begin by providing a brief overview of Path 1, MIPS, the Merit-based Incentive Payment System.

**Slide 6**

**What is MIPS?**

* **Combines multiple Medicare Part B programs into a single program**

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* **This new, single program is based on:**
  + **Quality (PQRS/VM-Quality Program)**
  + **Resource Use (Cost) (VM-Cost Program)**
  + **Advancing Care Information (Medicare MU\*)**
  + **Improvement Activities (new category)**

***Note: MACRA does not alter or end the Medicaid EHR Incentive Program***

**SCRIPT**

MIPS combines multiple Medicare Part B programs, which you may already be familiar with, into a single program. It takes the Medicare EHR Incentive Program, otherwise known as Medicare Meaningful Use, the Physician Quality Reporting System or PQRS, the Value-Based Payment Modifier or VM, it adds a fourth new category called Improvement Activities and combines them into this new program called MIPS. In MIPS, Meaningful Use has undergone a name change and is now referred to as the Advancing Care Information performance category. Also, please note that MIPS does not end or affect the Medicaid EHR Incentive Program. That program is scheduled to continue into Stage 3 and run through the year 2021. Participating in Medicaid Meaningful Use and MIPS concurrently requires separate attestations. PQRS is now referred to as the Quality performance category of MIPS. And the Value-based Payment Modifier is now the Cost performance category.

**Slide 7**

**Who is Eligible?**



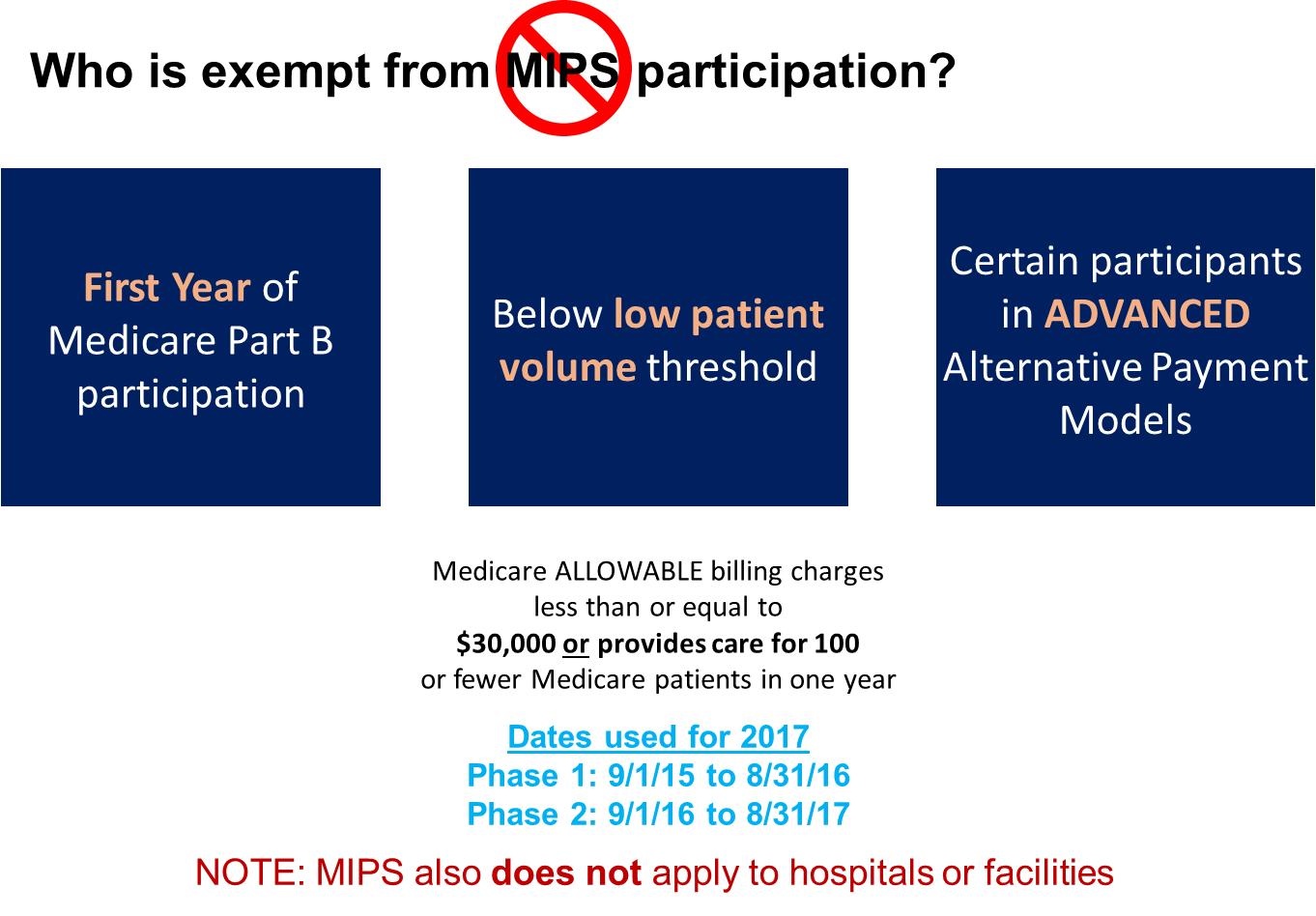
Note: The term Eligible Professional or “EP” is being replaced with Eligible Clinician or “EC”

**SCRIPT**

Next we’ll cover program eligibility. In the first two years of the program, performance years 2017 and 2018, there are five provider types that are eligible to participate: Doctors of Medicine, Doctors of Osteopathic Medicine, Physician Assistants, Nurse Practitioners, Certified Nurse Specialists and Certified Registered Nurse Anesthetists. Although not yet finalized, beginning in Program Year 3 and beyond, CMS expects to expand the list of eligible provider types to include several others such as Physical Therapists, Occupational Therapists, Certified Nurse Midwives and Licensed Clinical Social Workers. This expansion of eligible provider types will be finalized through future regulatory legislation. Please note that the term Eligible Professional or “EP” that has been previously used to reference participants in previous Medicare programs is being replaced in the Quality Payment Program with the term Eligible Clinician, or “EC”.

**Slide 8**

**Who is exempt from MIPS participation?**

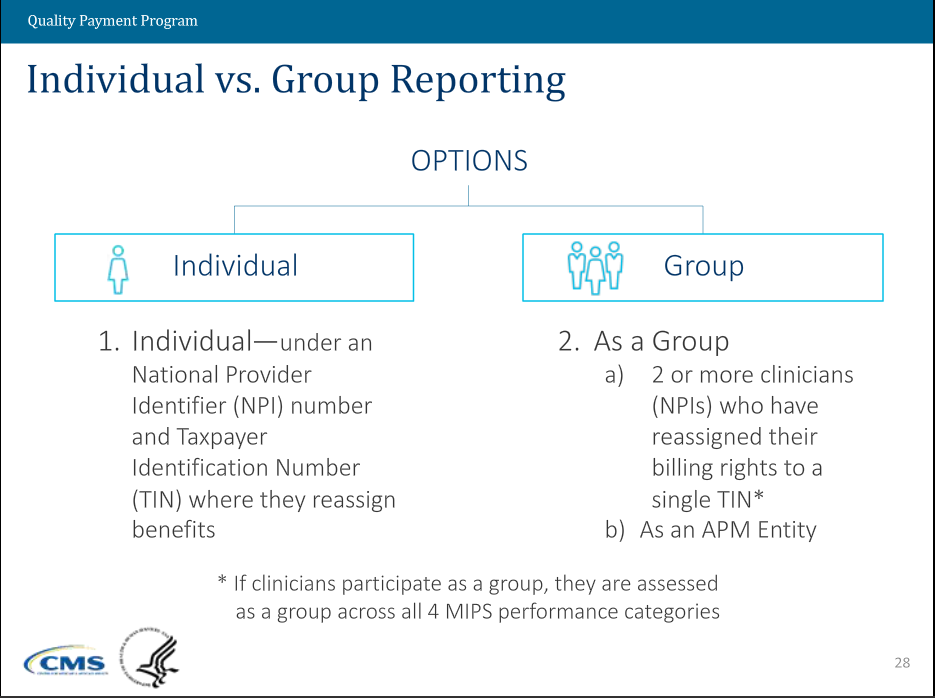


**SCRIPT**

There are 3 groups of clinicians who are NOT eligible to participate in MIPS despite being an eligible provider type. The first group consists of those who are in their first year of Medicare Part B participation. Clinicians are exempt from MIPS participation in the calendar year they first become credentialed to accept Medicare. The next group of providers exempt from MIPS participation are those who do not meet the “Low-Volume Threshold” for program participation. For the 2017 program year, the low volume threshold is set at Medicare allowable billing charges of less than or equal to $30,000 dollars or provides care for 100 or fewer Medicare patients in a 12 month period. To be a participant in MIPS, a clinician must exceed BOTH of these conditions. In a 12 month period, the provider must have more than $30,000 dollars in allowable Medicare Part B claims and provide care to more than 100 Medicare patients. If either of these conditions is not met, then the provider is exempt from participating in MIPS. The dates that CMS is using to calculate provider eligibility for 2017 is September 1st of 2015 to August 31st of 2016, with a second phase of calculations scheduled to take place using the dates of September 1, 2016 through August 31 of 2017. In April and May of this year, CMS will send letters to each medical practice detailing provider eligibility relative to this Low Volume Threshold. Additionally, the CMS QPP website previously mentioned at QPP.CMS.GOV will soon include the ability to query a provider by National Provider Identifier or NPI to determine program eligibility. The third group of providers exempt from MIPS participation are those who are significantly participating in an Advanced Alternative Payment Model which will be discussed more later in this video. Please note that MIPS also does not apply to hospitals or facilities.

**Slide 9**

**Individual vs. Group Reporting**

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\*If clinicians participate as a group, they are assessed as a group across all 4 MIPS performance categories

**SCRIPT**

There are different ways that providers can participate in the program, as an individual provider or as a group of providers. If participating as an individual, a provider is assessed separately under each NPI and Tax Identification Number combination. If the provider works under more than one Tax ID Number, program performance is calculated separately within each TIN and Medicare reimbursements are adjusted relative to that provider’s program performance at that location.

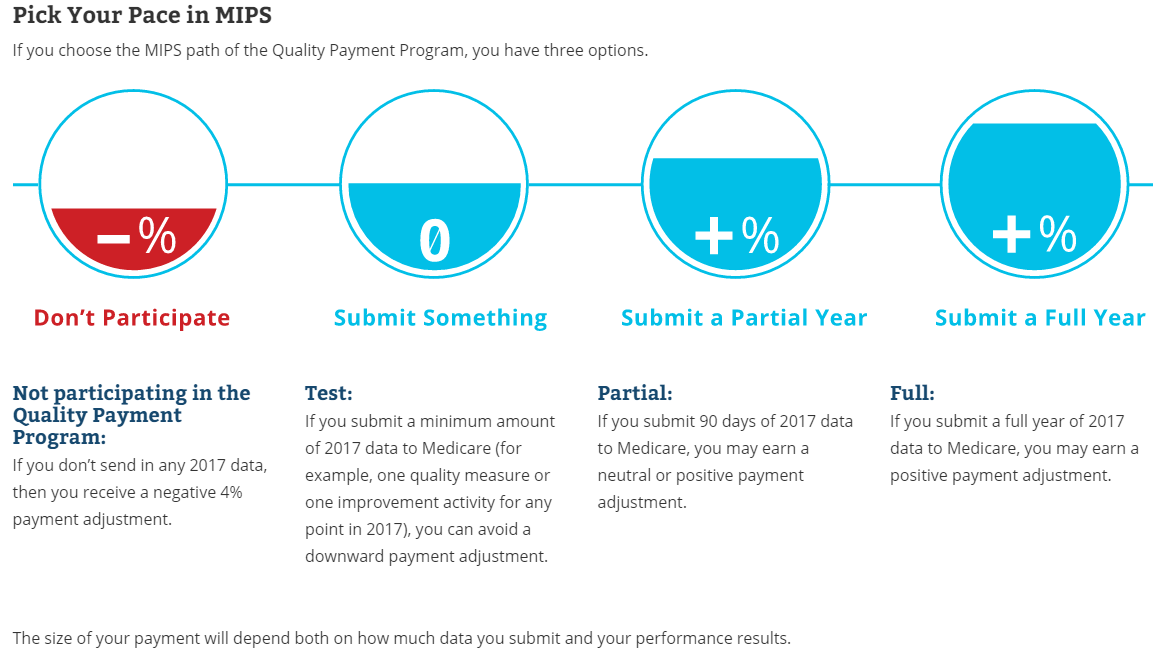
In the group participation option, two or more clinicians who have reassigned their billing rights to a single tax identification number are assessed as a group of participants. Members are assessed as a group across all four of the MIPS performance categories. Program performance is consolidated and all group members receive the same MIPS score and subsequent reimbursement rate. If choosing to report as a group, all ECs practicing under that TIN must report as part of that group. ECs within the group cannot override that group decision and choose to report individually.

Groups can also participate as an APM entity, for example as members of an Accountable Care Organization or ACO.

Whether participating as an individual or as a group, the Low-volume threshold remains the same. In terms of Group participation, the dollar value of claims and the number of patients seen is consolidated across all group members, thus the group as a whole must have more than $30,000 dollars in Medicare allowable charges and provide care to more than 100 Medicare patients in the 12 month period. In that way, group participation could be used to allow individual ECs who do not meet the low-volume threshold on their own to band together to meet eligibility requirements and participate in MIPS, potentially increasing Medicare reimbursement rates.

**Slide 10**

**“Pick Your Pace” in 2017**

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**Note: Total financial impact will depend on how much data you submit and your performance results**

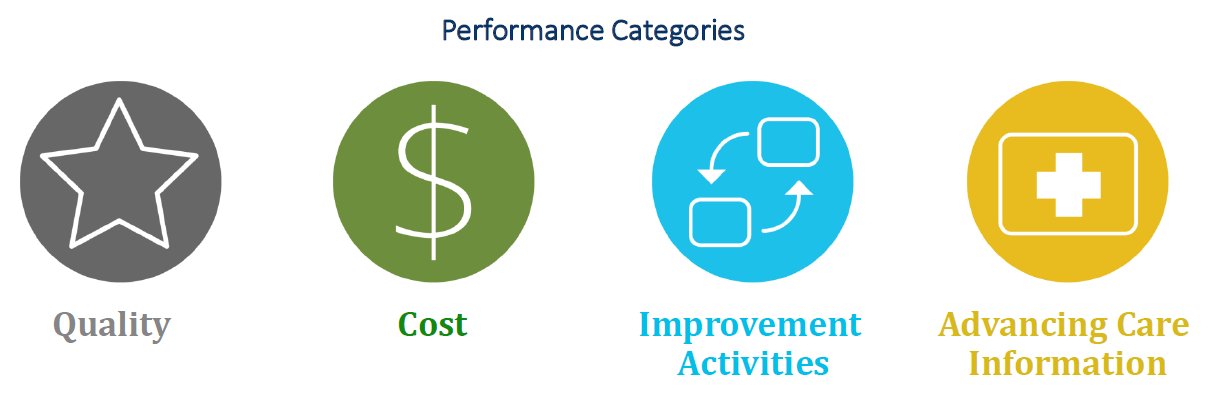
**SCRIPT**

To allow clinicians time to transition into the Quality Payment Program in 2017, CMS has introduced something they call “Pick Your Pace” participation options. In the first option, which is Don’t Participate, the MIPS eligible clinician chooses not to submit any of the required MIPS data to CMS. A MIPS eligible clinician choosing this option will receive the maximum payment adjustment associated with the 2017 performance year, which is a 4% reduction on Medicare Part B reimbursements in calendar year 2019. The second participation option is “Submit Something”. Under this option, participants test the system by submitting a minimal amount of 2017 data to Medicare, for example one quality measure or one improvement activity, for any point in 2017. Doing so will maintain the clinician’s current Medicare reimbursement rate, eliminating the downward payment adjustment referenced in the first option. In the third option, participants submit a minimum of 90 days’ worth of data across all MIPS performance categories. Clinicians can maximize the financial impacts of MIPS by choosing this option. In the fourth participation option, Submit a Full Year, clinicians report across all MIPS performance categories, similar to the previous option, but report data covering the entire 2017 calendar year. Maximum financial impacts can be realized through the partial year and full year options with reporting periods ranging anywhere from 90 to 365 days. Clinicians may find that they score best by reporting data for the entire calendar year.Total financial impact will depend on how much data is submitted and the performance results.

**Slide 11**

**MIPS Composite Performance Score (CPS)**

**A single MIPS composite performance score will factor performance in 4 weighted performance categories on a 0-100 point scale:**

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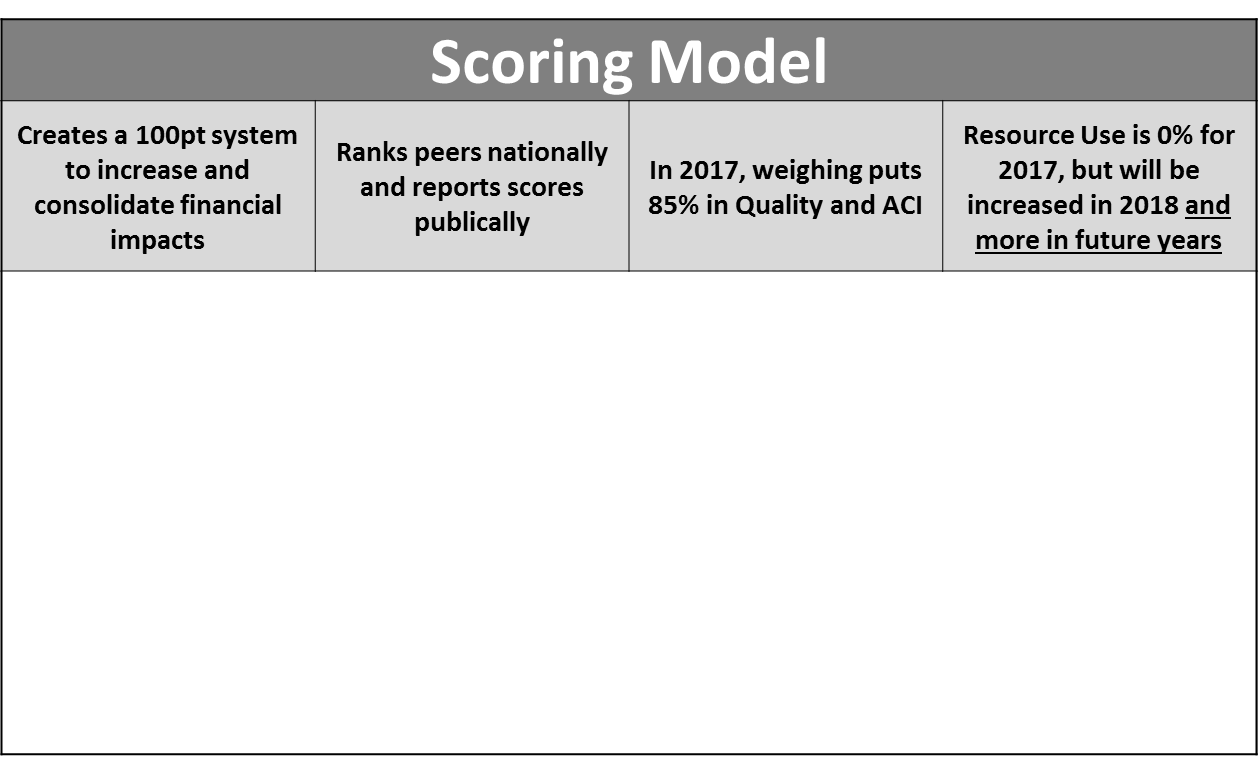
**SCRIPT**

Overall MIPS program performance is rated through the MIPS Final Score, a single composite score that factors weighted performance in the 4 MIPS performance categories on a 100 point scale. This Final Score is then compared to the overall performance threshold. In the first two years of the program, CMS will establish the Performance Threshold which must be met to maintain Medicare reimbursement rates. In future years, the Performance Threshold will be established based on the mean or median of the prior period’s Final Scores. Those who score below the threshold will see negative payment adjustments to their Medicare reimbursement rates. Those who score above it will see positive rate adjustments. Any clinicians who score in the bottom 25% of total MIPS participants will receive the maximum penalty for that program year, which is 4% in Year 1 and increasing to 9% in future years.

Performance category weights may be adjusted if there are not sufficient measures and activities applicable for each type of clinician, including assigning a scoring weight of zero for a performance category. Reweighting of the performance categories is automatic for some participants, such as hospital-based providers, with an application process available for other conditions, such as extreme or uncontrollable circumstances.

**Slide 12**

**2017 MIPS Components & Scoring  
(the transition year)**

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**Slide 21**

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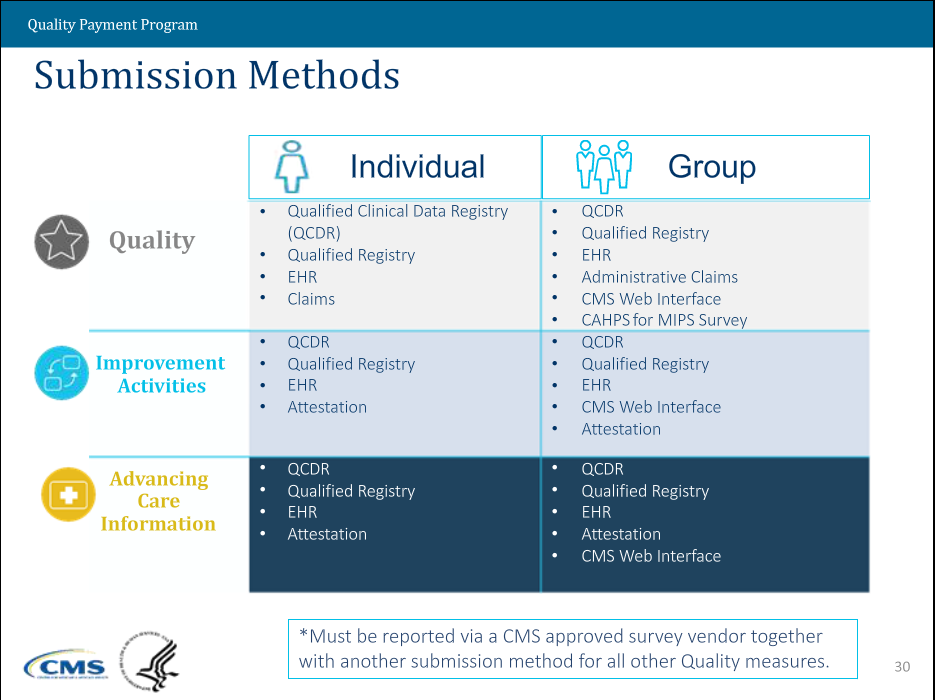
**SCRIPT**

As part of the first transition year, to collect additional clinician data and give participants more time to become acclimated with what is a relatively new performance category for many clinicians, CMS has weighted the cost category at 0% in 2017, thus in the first performance year, participants are only being measured against 3 of the 4 MIPS performance categories. In 2017, Improvement Activities is worth 15% of the Final Score, Advancing Care Information is worth 25% and Quality is worth 60%. In future program years, the Cost category will be used with its weight increasing each year until it is of equal weight to Quality at 30% each.

**Slide 13**

**How Does CMS Get the Data?**

**Data Submission Options**

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**SCRIPT**

There are several options available for submitting MIPS data to CMS, and participants need to take the time to plan for and implement which submission option will be used. Options vary based on Individual or Group reporting. Only one submission method can be used within a single performance category, but different options can be used for each category. Also, within the Quality performance category, the submission method chosen may significantly impact the ECs category score, as quality measure benchmarks have been established separately for each data submission option. With this variation in benchmarks relative to the reporting method, what is a high quality measure score using one submission method may translate to a much lower quality measure score utilizing a different submission option. Quality measure benchmark information, broken down by data submission method, can be viewed and downloaded at QPP.CMS.GOV.

**Slide 14**

**Payment Adjustments**

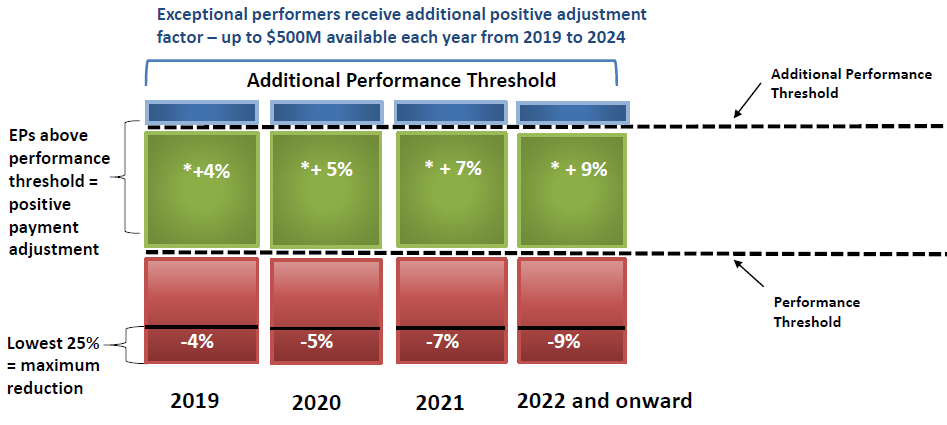
* **Adjustments applied 2 years after performance year (e.g. 2019 adjustment is based on 2017 performance year)**
* **The program is budget neutral, so ECs receiving negative adjustments pay for those receiving positive adjustments**
* **Linear adjustment based on composite score, as compared to performance threshold (positive, negative, or zero/neutral)**
* **Those scoring in the bottom 25% will automatically be adjusted down to the maximum penalty for that program/payment year**
* **Higher scores receive proportionally larger incentive payments, up to 3x the maximum positive adjustment for the year**
* **Highest performers eligible for “Exceptional Performance Bonus”**
  + **Additional payment adjustment of +10% for ECs in the top 25%**
  + **ECs have the potential to receive a 37% increase in 2024!**

**SCRIPT**

If applicable based on performance, adjustments to a clinician’s or group’s Medicare Part B reimbursement rate is applied 2 years after the performance year, as was the case in the former legacy programs, Meaningful Use and PQRS. So the 2017 performance year affects the 2019 payment year. MIPS, for the most part, has been designed to be budget neutral, so ECs receiving negative rate adjustments pay for those receiving positive rate adjustments. Unlike in the previous legacy programs, the adjustments are linear based on the Final Score as compared to set performance threshold. Adjustments in the first performance year can range anywhere between negative 4% and positive 4%. As previously mentioned, those scoring in the bottom 25% of total participants will automatically be adjusted down to the maximum penalty for that program year. Higher scores receive proportionally larger rate increases, up to three times the maximum positive adjustment for that year. This 3 times modifier will be used to maintain budget neutrality. The best performers will also be eligible for something called the “Exceptional Performance Bonus”, an additional pool of $500 million dollars a year to be awarded to top program performers. Clinicians in the top 25% of total participants may receive up to an additional 10% increase in reimbursement rates as a reward for outstanding performance. This means that in future years of the program, ECs have the potential to receive a 37% increase in Medicare reimbursement rates.

**Slide 15**

**MIPS Incentives and Penalties Summarized**

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**SCRIPT**

In summary, the MIPS performance threshold is established each year and in future years will be the average of Final Scores received in the prior performance year. Those scoring below the threshold will receive a negative payment adjustment on Medicare Part B rates, with those in the bottom quartile automatically assessed the maximum penalty for that year. Those scoring above the performance threshold will receive proportionally higher Medicare rate increases, up to 3 times the maximum adjustment for that year, with those in the top quartile of performers receiving up to an additional 10% rate increase for exceptional performance.

**Slide 16**

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**The other fork in the path to Quality Payments**

**SCRIPT**

We’ll now discuss the other participation path of the Quality Payment Program, Alternative Payment Models.

**Slide 17**

**Alternative Payment Models (APMs)**

**What are they?**

* **Alternative Payment Model or APM is a generic term describing a payment model in which providers take responsibility for cost and quality performance and receive payments to support the services and activities designed to achieve high value**
* **According to MACRA, APMs in general include:**
  + **Medicare Shared Savings Program (MSSP) ACOs**
  + **Demonstrations under the Health Care Quality Demonstration Program**
  + **CMS Innovation Center Models**
  + **Demonstrations required by Federal Law**
* **MACRA does not change how any particular APM pays for medical care and rewards value**
* **APM participants may receive favorable scoring under certain MIPS performance categories**
* **Only some APMs are “Advanced” APMs**

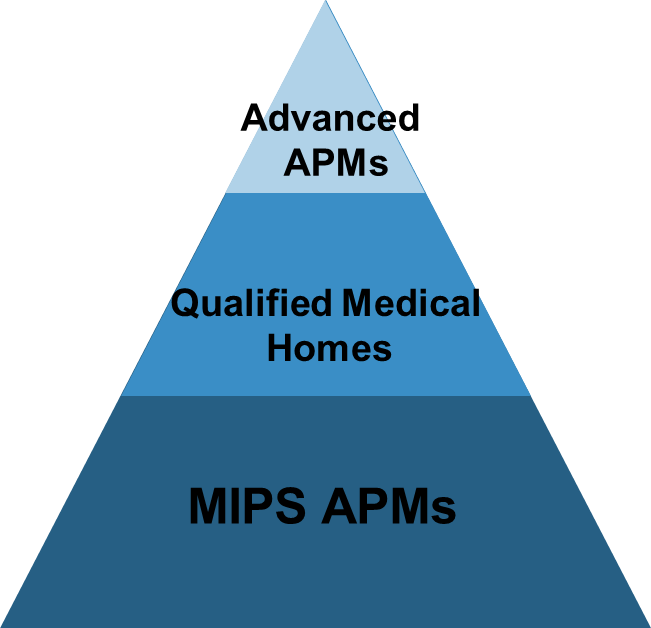
**SCRIPT**

Alternative Payment Model or APM is a generic term describing a payment model in which providers take responsibility for cost and quality performance and receive payments to support the services and activities designed to achieve high value. According to MACRA, APMs in general include Medicare Shared Savings Program ACOs, demonstrations under the Health Care Quality Demonstration Program, CMS Innovation Center Models such as the Qualified Medical Home and demonstrations required by Federal Law. The Quality Payment Program does not change how any particular APM pays for medical care and rewards value. Instead, the QPP enhances that payment methodology by adding additional incentives for ECs. And if applicable, APM participants may receive favorable scoring under certain MIPS performance categories. The long term goal of the Quality Payment Program is to significantly increase participation in the highest level of APMs, those meeting the criteria to be defined as Advanced APMs.

**Slide 18**

**Alternative Payment Models**

* **“Advanced” APMs – Term established by CMS; these have the greatest risks and offer potential for greatest rewards**
* **Qualified Medical Homes have different risk structure but are otherwise treated as Advanced APMs**
* **MIPS APMs receive favorable MIPS scoring**

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**SCRIPT**

Within the QPP, there are 3 types of Alternative Payment Models.

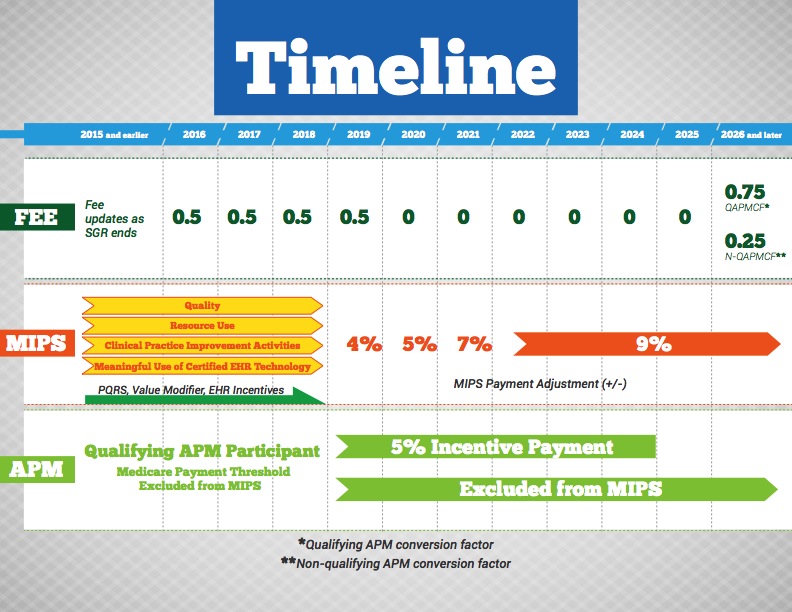
At the top we have Advanced APMs, a term established by CMS which denotes those APMs which have the greatest financial risks for providers and also offer the greatest potential for rewards. Three criteria need to be met for an APM to be deemed an Advanced APM. First, 50% or more of the APMs participants must use certified EHR technology or CEHRT. The entity must report and at least partially base clinician payments on quality measures which are comparable to those available to participants of MIPS. Finally, and perhaps most importantly, to be an Advanced APM, participants must bear “more than nominal risk” for monetary losses for poor performance. This level of risk is defined as the lesser of 8% of total Medicare revenues or 3% of total Medicare expenditures. Current examples of Advanced APMs include, but are not limited to, Medicare Shared Savings Program ACOs Tracks 2 and 3, Next Generation ACOs, the Comprehensive ESRD Care Model, and the Oncology Care Model Track 2. A complete listing of available Advanced APMs can be found at QPP.CMS.GOV. Advanced APM benefits include shared savings, flexible payment bundles and other desirable features, none of which are altered by the Quality Payment Program. As previously mentioned, the QPP adds additional financial incentives on top of the current APM payment model. In 2019 through 2024, ECs significantly participating in Advanced APMs will receive a lump sum bonus equal to 5% of their Medicare Part B reimbursements for the measurement year. Additionally, starting in 2026, annual baseline Medicare payment updates will be higher for Advanced APM participants than for MIPS participants. Finally, since Advanced APMs include their own requirements for EHR use and quality reporting, Advanced APM participants are exempt from participating in the MIPS track of the Quality Payment Program.

Next we have Qualified Medical Homes which are Certified Medical Home models which have been expanded under CMS authority. They have different risk structures than the previous category but are otherwise treated as Advanced APMs. To date, the Comprehensive Primary Care Plus or CPC+ program is the only Medical Home model available which qualifies as an Advanced APM.

Finally we have MIPS APMs, which make up the vast majority of current APMs available, including the Medicare Shared Savings Program Track 1 ACOs. To qualify as a MIPS APM, the entity must participate in a model under an agreement with CMS. It must include at least one MIPS eligible clinician on a participant list. And finally, the APMs payment model must be based on performance against cost and quality measures. The Advanced APM benefits do not apply to MIPS APMs. Their members must participate in MIPS to receive any favorable payment adjustments. They do not qualify for the 5% lump sum bonus and are not eligible for the higher baseline annual updates beginning 2026. There are, however, still significant program benefits for participating in a MIPS APM. In 2017, MIPS APM participants automatically receive full credit in the Improvement Activities category of MIPS. They still receive the shared savings rewards built into the APMs payment model and these clinicians are eligible for MIPS rate increases, which continue indefinitely versus the limited 6 years planned for the 5% Advanced APM lump sum bonuses.

**Slide 19**

**Quality Payment Program Timeline**



**SCRIPT**

Taking a look at the Quality Payment Program timeline, we see that the Medicare Physician Fee Schedule will still see modest rate increases through 2019. Between the years 2020 and 2025 the only way to receive Medicare rate increases will be to participate in one of the 2 paths of the Quality Payment Program. In 2026, the Medicare Fee Schedule will once again see annual positive adjustments, with the rate of increase dependent on whether or not the clinician is significantly participating in an Advanced APM. In the MIPS track, reimbursement rates will be adjusted within the range of plus or minus 4% in the first year and increasing to 9% in 2022 and beyond. Those clinicians significantly participating in an Advanced APM will receive lump sum incentive payments equal to 5% of their Medicare reimbursements and are exempt from participating in MIPS.

**Slide 20**

**Concluding Thoughts**

* **We are in the beginning stages of long overdue payment reform**
* **We will continue to see the QPP evolve over time**
* **Long term goal is to push ECs into Advanced APMs**
* **Potential MIPS incentives are significant for high performers (37%)**
* **There is a risk for significant financial penalty (-9%)**
* **As the program develops, there is the potential for a 46% gap in Medicare reimbursement rates between the highest and lowest performers**
* **Each participant’s MIPS scores will be publically available on the CMS Physician Compare website, allowing patients to shop for providers demonstrating high quality and value**

**SCRIPT**

In summary, we are in the beginning stages of long overdue Medicare program payment reform. As was the case with the legacy programs it replaces, we will continue to see the QPP evolve over time. The long term goal of the program is to push Eligible Clinicians into Advanced APMs. Potential MIPS incentives are significant for high performers and could reach as high as 37% as the program matures. There is also the risk of significant financial penalties for poor performance. As the program develops, there is the potential for a 46% gap in Medicare reimbursement rates between the highest and lowest performers. Also, each participant’s MIPS scores will be publically available on the CMS Physician Compare website, allowing patients to shop for providers demonstrating high quality and value.