MACRA & MIPS: UNDERSTANDING THE QUALITY PAYMENT PROGRAM
Thank Goodness I Am In San Diego
How To Best Describe MACRA & MIPS?
Background

PUBLIC LAW 114–10—APR. 16, 2015  129 STAT. 87

Public Law 114–10
114th Congress

An Act
To amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and strengthen Medicare access by improving physician payments and making other improvements, to reauthorize the Children’s Health Insurance Program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.
(a) Short Title.—This Act may be cited as the “Medicare Access and CHIP Reauthorization Act of 2015”.
(b) Table of Contents.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.
TITLE I—SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION
Sec. 101. Repealing the sustainable growth rate (SGR) and improving Medicare payment for physicians’ services.
Sec. 102. Priorities and funding for measure development.
Sec. 103. Encouraging care management for individuals with chronic care needs.
Sec. 104. Empowering beneficiary choices through enhanced access to information in health provider networks.
Sec. 105. Expanding availability of Medicare data.
Sec. 106. Reducing administrative burdens and other provisions.

TITLE II—MEDICARE AND OTHER HEALTH EXTENDERS
Subtitle A—Medicare Extenders

Sustainable Growth Rate

~21%

The Quality Program

Merit-based Incentive Payment System (MIPS)

Alternative Payment Models (APMs)
Quality Payment Program Options

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

- Quality
- Cost
- Advancing Care Information
- Improvement Activities

**For Advanced APMs**

- Advanced APM-Specific Rewards + 5% Increase On Part B Reimbursements

**Demonstration Programs**

- Health Care Quality Demonstration Program
- ACA & Other Legislation

**Alternative Payment Models (APMs)**

- CMS Innovation Center Payment & Delivery Models
- Medicare Shared Savings Program (MSSP)
  - Track 2, Advanced APM
  - Track 3, Advanced APM
Merit-based Incentive Payment System

Three Separate Quality And Value Programs...

- Physician Quality Reporting System
- Value-Based Modifier
- Meaningful Use

...Combined into One Comprehensive Program With Four Categories

- Cost: Based On Medicare Adjudicated Claims.
- Advancing Care Information: Report Up To 7 Or 9 Measures, Depending On Edition Of CEHRT.
- Improvement Activities: Choose Up To 4 From 112 Activities Across Nine Sub-Categories.
## Category Weighting

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
<td>50%</td>
<td>30%</td>
</tr>
<tr>
<td>Cost</td>
<td>0%</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
</tbody>
</table>
## Category Re-Weighted For ED Exemption

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>85%</td>
<td>75%</td>
<td>55%</td>
</tr>
<tr>
<td>Cost</td>
<td>0%</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
</tbody>
</table>
## Merit-based Incentive Payment System

<table>
<thead>
<tr>
<th>Score x Category Weight</th>
<th>+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score x Category Weight</td>
<td>+</td>
</tr>
<tr>
<td>Score x Category Weight</td>
<td>+</td>
</tr>
</tbody>
</table>

### Composite Score

<table>
<thead>
<tr>
<th>Payment Adjustment</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exceptional Performance Bonus</td>
<td>70 - 100 Point</td>
<td>70 - 100 Point</td>
</tr>
<tr>
<td>Positive Adjustment</td>
<td>4 - 69 Points</td>
<td>16 - 69 Points</td>
</tr>
<tr>
<td>Performance Threshold - Neutral Adjustment</td>
<td>3 Points</td>
<td>15 Points</td>
</tr>
<tr>
<td>Negative Adjustment</td>
<td>0 - 2 Points</td>
<td>0 - 14 Points</td>
</tr>
</tbody>
</table>

Score x 100
What is at Stake With MIPS

Medicare Part B Reimbursement

±4% ±5% ±7% ±9% ±9% ±9%

2019 2020 2021 2022 Onward...

Potential For 3x Adjustment Due To Budget Neutrality

…Plus Opportunity For Additional 10% Adjustment (Non-budget Neutral) For Top Performers

The Low Volume Threshold Has Been Increased

2017

Part B Revenue > $30,000
And
Part B Patient Count > 100

2018

Part B Patient Count > 200
And
Part B Revenue > $90,000
MIPS Reporting Mechanisms

- Individual Provider
- Group Practice

Reported Automatically Based On Medicare Claims
MIPS Reporting Mechanisms

**Individual Provider**
- Claims
- Electronic Health Record
- Qualified Clinical Data Registry
- Qualified Registry

**Group Practice**
- Claims
- Electronic Health Record
- Qualified Clinical Data Registry
- Qualified Registry
- CMS Web Interface

**Quality**
- Electronic Health Record
- Qualified Clinical Data Registry
- Qualified Registry

**Improvement Activities**
- Electronic Health Record
- Qualified Clinical Data Registry
- Qualified Registry

**Advancing Care Information**
- Electronic Health Record
- Qualified Clinical Data Registry
- Qualified Registry
- Attestation
- CMS Web Interface
Cost

2017

- Includes The Medicare Spending Per Beneficiary (MSPB)
- Total Per Capita Cost Measures, And 10 Episode-based Cost Measures

2018

- Includes The Medicare Spending Per Beneficiary (MSPB)
- Total Per Capita Cost Measures For The Cost Performance Category For The 2018 MIPS Performance Period

“We Expect To Propose New Cost Measures In Future Rulemaking…”

Reference: 2018 Quality Program Year 2 Final Rule Overview
Cost

Note: The scatter plot shows performance among a representative sample of all TINs with Quality and Cost Composite Scores reflecting standard deviations from the mean for each Composite Score.
## Exhibit 7. Per Capita Costs for Your Attributed Medicare Beneficiaries

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Cost Measure</th>
<th>Your Eligible Cases or Episodes</th>
<th>Your Per Capita or Per Episode Costs</th>
<th>Benchmark</th>
<th>Benchmark – 1 Standard Deviation</th>
<th>Benchmark + 1 Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Capita Costs for All Attributed Beneficiaries</td>
<td>Per Capita Costs for All Attributed Beneficiaries</td>
<td>2</td>
<td>$10,101</td>
<td>$11,293</td>
<td>$8,096</td>
<td>$14,490</td>
</tr>
<tr>
<td>Per Capita Costs for Beneficiaries with Specific Conditions</td>
<td>Medicare Spending per Beneficiary</td>
<td>208</td>
<td>$20,171</td>
<td>$20,258</td>
<td>$18,679</td>
<td>$21,837</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Diabetes</td>
<td>1</td>
<td>$4,797</td>
<td>$16,369</td>
<td>$11,437</td>
<td>$21,302</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>0</td>
<td>—</td>
<td>$25,475</td>
<td>$17,537</td>
<td>$33,412</td>
</tr>
<tr>
<td>Coronary Artery Disease (CAD)</td>
<td>Coronary Artery Disease (CAD)</td>
<td>0</td>
<td>—</td>
<td>$18,614</td>
<td>$13,013</td>
<td>$24,214</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>Heart Failure</td>
<td>0</td>
<td>—</td>
<td>$28,488</td>
<td>$19,527</td>
<td>$37,449</td>
</tr>
</tbody>
</table>
Quality

Total Quality Performance Category Score = Points earned on required 6 quality measures + Any bonus points

Maximum number of points*

Reference: CSM, Quality Payment Program – Executive Summary
Does The Reporting Mechanism Matter?
Let’s Play - Who Gets A Better Score?

Measure #317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented – National Quality Strategy Domain: Community / Population Health

**DESCRIPTION:**
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
Who Gets A Better Score?

<table>
<thead>
<tr>
<th>Normal BP Reading</th>
<th>Systolic PB mmHg</th>
<th>Diastolic BP mmHg</th>
<th>Recommended Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt; 120</td>
<td>And &lt; 80</td>
<td>No Follow-Up Required</td>
</tr>
<tr>
<td>Pre-Hypertensive BP</td>
<td>≥ 120 And ≤ 139</td>
<td>Or ≥ 80 And ≤ 89</td>
<td>Referral To Alternative/Primary Care Provider</td>
</tr>
<tr>
<td>Reading</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Hypertensive</td>
<td>≥ 140</td>
<td>Or ≥ 90</td>
<td>Referral To Alternative/Primary Care Provider</td>
</tr>
<tr>
<td>Reading</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Who Gets A Better Score?

<table>
<thead>
<tr>
<th>Provider</th>
<th>Successfully Completes Measure</th>
<th>Reporting Mechanism</th>
<th>Measure Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider A</td>
<td>85%</td>
<td>Claims</td>
<td>7</td>
</tr>
<tr>
<td>Provider B</td>
<td>80%</td>
<td>Registry/QCDR</td>
<td>8</td>
</tr>
<tr>
<td>Provider C</td>
<td>47%</td>
<td>EHR</td>
<td>10</td>
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</table>
## Measure 317 Scoring

<table>
<thead>
<tr>
<th>Submission_Method</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>Claims</td>
<td>42.13 - 50.44</td>
<td>50.45 - 59.06</td>
<td>59.07 - 68.11</td>
<td>68.12 - 78.63</td>
<td>78.64 - 92.67</td>
<td>92.68 - 99.53</td>
<td>99.54 - 99.99</td>
<td>100.00</td>
</tr>
<tr>
<td>EHR</td>
<td>17.90 - 22.55</td>
<td>22.56 - 25.80</td>
<td>25.81 - 28.83</td>
<td>28.84 - 31.69</td>
<td>31.70 - 34.67</td>
<td>34.68 - 38.96</td>
<td>38.97 - 46.26</td>
<td>&gt;= 46.27</td>
</tr>
<tr>
<td>Registry/QCDR</td>
<td>24.74 - 35.47</td>
<td>35.48 - 47.87</td>
<td>47.88 - 62.14</td>
<td>62.15 - 71.64</td>
<td>71.65 - 79.36</td>
<td>79.37 - 88.85</td>
<td>88.86 - 98.87</td>
<td>&gt;= 98.88</td>
</tr>
</tbody>
</table>
### Examples Of Registry Scoring Benchmarks

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure ID</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>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</td>
<td>116</td>
<td>23.19 - 31.47</td>
<td>31.48 - 63.74</td>
<td>63.75 - 99.99</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>100.00</td>
</tr>
<tr>
<td>Documentation of Current Medications in the Medical Record</td>
<td>130</td>
<td>61.27 - 82.11</td>
<td>82.12 - 91.71</td>
<td>91.72 - 96.86</td>
<td>96.87 - 99.30</td>
<td>99.31 - 99.99</td>
<td>--</td>
<td>--</td>
<td>100.00</td>
</tr>
<tr>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>226</td>
<td>76.67 - 85.53</td>
<td>85.54 - 89.87</td>
<td>89.88 - 92.85</td>
<td>92.86 - 95.14</td>
<td>95.15 - 97.21</td>
<td>97.22 - 99.10</td>
<td>99.11 - 99.99</td>
<td>100.00</td>
</tr>
<tr>
<td>Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain</td>
<td>254</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented</td>
<td>317</td>
<td>24.74 - 35.47</td>
<td>35.48 - 47.87</td>
<td>47.88 - 62.14</td>
<td>62.15 - 71.64</td>
<td>71.65 - 79.36</td>
<td>79.37 - 88.85</td>
<td>88.86 - 98.87</td>
<td>&gt;= 98.88</td>
</tr>
<tr>
<td>Appropriate Testing for Children with Pharyngitis</td>
<td>66</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Acute Otitis Externa (AOE): Topical Therapy</td>
<td>91</td>
<td>60.47 - 69.56</td>
<td>69.57 - 78.25</td>
<td>78.26 - 83.01</td>
<td>83.02 - 87.97</td>
<td>87.98 - 93.32</td>
<td>93.33 - 99.99</td>
<td>--</td>
<td>100.00</td>
</tr>
<tr>
<td>Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy - Avoidance of Inappropriate Use</td>
<td>93</td>
<td>73.91 - 84.74</td>
<td>84.75 - 90.90</td>
<td>90.91 - 95.82</td>
<td>95.83 - 99.99</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>100.00</td>
</tr>
</tbody>
</table>
Improvement Activities

\[
\text{Improvement Activities Performance Category Score} = \frac{\text{Total number of points scored for completed activities}}{\text{Total maximum number of points (40)}} \times 100
\]

Reference: CSM, Quality Payment Program – Executive Summary
Improvement Activities

Total points = 40

Activity Weights
- Medium = 10 points
- High = 20 points

Alternate Activity Weights*
- Medium = 20 points
- High = 40 points

*For clinicians in small, rural, and underserved practices or with non-patient facing clinicians or groups

Full credit for clinicians in a patient-centered medical home, Medical Home Model, or similar specialty practice

Reference: CSM, Quality Payment Program – Executive Summary
Improvement Activities

There Are Some Good Options In This Category

- Annual Registration In The Prescription Drug Monitoring Program
- Consultation Of The Prescription Drug Monitoring Program >>>> High Activity Weighting Worth 2X
- Participation In A 60-day Or Greater Effort To Support Domestic Or International Humanitarian Needs
- Participation On Disaster Medical Assistance Team, Registered For 6 Months
- TCPI Participation
And This Could Be The Easiest Way To Pass

If You Do...

- Annual Registration In The Prescription Drug Monitoring Program 10
- Consultation Of The Prescription Drug Monitoring Program 20
- Participation On Disaster Medical Assistance Team, Registered For 6 Months 10

$$\text{Improvement Activities Performance Category Score} = \frac{40}{\text{Total maximum number of points (40)}} \times 100 = 40 \times 15\% = 15 \text{ Points}$$
You Could Do It, But Why??
Medpac Is Recommending Change

MIPS process is burdensome and inequitable

- Reporting burden
  - Over $1 billion in reporting burden for clinicians in 2017 alone
  - CMS supports six reporting methods for the MIPS quality category plus two new systems
- Much of the reported information is not meaningful
  - Only a few MIPS quality measures assess meaningful outcomes
  - Other categories (ACI, CPIA) not shown to be associated with high-value care
- Small sample sizes
- Each clinician is scored on different measures representing different levels of effort
- Results in non-comparable scores across clinicians, but nonetheless is used to allocate payment

Many exceptions, modifications and adjustments

- CMS has exempted more clinicians in 2018 than are required to participate
- Special rules and reweighting
- Arbitrary payment adjustments
  - Near-term: Lots of effort, minimal adjustments because of low standard (3/100 points then 15/100 points)
  - Longer-term: Small differences in apparent performance will result in big payment differences (penalties increase over time and compressed distribution—most will score high)
- Overall, system is inequitable, burdensome, and will not improve care for beneficiaries nor move the Medicare program and clinicians towards high-value care

Reference: Assessing payment and updating payments: physician and other health professional services; and Alternative to the Merit-based Incentive Payment System (MIPS), The Medicare Payment Advisory Commision
CMS Estimated Adjustments For 2018 Reporting Year

FIGURE A: Illustrative Example of MIPS Payment Adjustment Factors Based on Final Scores and Performance Threshold and Additional Performance Threshold for the 2020 MIPS Payment Year

Reference: 2018 Quality Program Final Rule, P809
Thank You

Any Questions?