From Surviving to Thriving in the QPP World
Today’s Objectives

➢ Brief MACRA Overview
➢ Where are we going?: Advanced Alternative Payment Models (APMs)
➢ Where are we now? Merit Incentive-Based Payment System (MIPS)
➢ MIPS Categorical Scoring Summary
➢ Circumstantial Action Steps
  ➢ Immediate Questions
  ➢ Short Term Solutions
  ➢ Long Term Strategy
➢ Real World Experience
Medicare Access and CHIP Reauthorization Act of 2015

➢ “MACRA” Out; “QPP: Quality Payment Program” In

➢ Passed 92-8 in Senate, 392-37 in the House

➢ 2 payment models referred to as the Quality Payment Program

  ➢ Merit Incentive-Based Payment System (MIPS)
  ➢ Advanced Alternative Payment Models (APMs)
Where are we going? APMs

...and why are we in this handbasket
2017 APMs qualified as “Advanced”

- Medicare Shared Savings Program (MSSP) Tracks 1+, 2 & 3
- Comprehensive Primary Care Plus (CPC+)
- Comprehensive End-stage Renal Disease Care Model
- Oncology Care Model
- Next Generation (NextGen) Model
- Vermont Medicare ACO All-payer model

Key Takeaway: 90%+ of ACOs currently are MSSP Track 1, these entities will be scored in MIPS.
Advanced Alternative Payment Models (APMs)

Generic term for physicians receiving “greater than nominal” reimbursements via risk-bearing arrangements

To Qualify:
- Must use Certified Electronic Health Record Technology (CEHRT)
- Base payment for services on quality measures comparable to those in MIPS
- Be listed on 1 of 3 APM ‘Eligible Providers’ publications from CMS during a performance year
- Meet payment thresholds:

<table>
<thead>
<tr>
<th>Metric</th>
<th>2019-2020</th>
<th>2021-2022</th>
<th>2022 and Later</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Patients</td>
<td>25%</td>
<td>50%</td>
<td>75%</td>
</tr>
<tr>
<td>% of Payments</td>
<td>25%</td>
<td>50%</td>
<td>75%</td>
</tr>
<tr>
<td>Source</td>
<td>From a Medicare eligible APM</td>
<td>From any payer eligible APM, with at least 25% from a Medicare APM</td>
<td></td>
</tr>
</tbody>
</table>

Key Takeaway: APM thresholds will continue to be more stringent
What is the benefit of being in an APM?
Where are we now?: MIPS

“If confusion is the first step to knowledge, I must be a genius.”
~ Larry Leissner
Merit Incentive-Based Payment System

Key Takeaway: The Composite MIPS Score will be publicly available!
MIPS Composite Scoring

Composite Scores

2017
- 60% Quality
- 25% Cost
- 15% Improvement Activities
- 15% Advancing Care Information

2018
- 50% Quality
- 25% Cost
- 15% Improvement Activities
- 15% Advancing Care Information

2019
- 30% Quality
- 25% Cost
- 15% Improvement Activities
- 30% Advancing Care Information
Financial Impact Over Time

Minimum and Maximum Adjustment for full MIPS participation

-4% 2019 +4% up to 3X 10% exceptional performance bonus

-5% 2020 +5% up to 3X

-7% 2021 +7% up to 3X

-9% 2022 +9% up to 3X

*Potentially up to 3 times these rates plus up to a 10% exceptional performance bonus

Key Takeaway: MIPS is budget neutral, losers penalties pay the winners bonuses
Wait, who is “We”? 

- Medicare Part B clinicians billing more than $30,000 a year OR
- Caring for more than 100 Medicare patients a year

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
MIPS: Categorical Scoring

It is really confusing!!!
Quality (60%)

- 6 measures must be reported or a specialty measure set
  - 1 must be an outcome measure
  - At least 20 patients per measure
  - 90 day reporting window
  - 272 measures available

- Report on 50% of eligible patients in 2017, regardless of payer

- Bonus points available for:
  - Reporting via QCDR, EHR, or web-interface
  - Additional high priority or outcomes measure
Advancing Care Information 25%

Key Takeaway: You can only earn ACI credit if you’re on an EHR
### ACI: Base Score

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect Patient Health Information</td>
<td>Security Risk Analysis</td>
</tr>
<tr>
<td></td>
<td>E-Prescribing</td>
</tr>
<tr>
<td></td>
<td>Provide Patient Access</td>
</tr>
<tr>
<td>Electronic Prescribing</td>
<td></td>
</tr>
<tr>
<td>Patient Electronic Access</td>
<td></td>
</tr>
<tr>
<td>Health Information Exchange*</td>
<td>Send a Summary of Care*</td>
</tr>
<tr>
<td>Health Information Exchange*</td>
<td>Request/Accept Summary of Care*</td>
</tr>
</tbody>
</table>

**Key Takeaway:** 2014 Certified EHRs are all able to do this
### ACI: Performance Score

#### ACI Performance Measures (2014 CEHRT)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Performance Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide Patient Access</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Up to 20%</td>
</tr>
<tr>
<td>View, Download, and Transmit</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Immunization Registry Reporting</td>
<td>0 or 10%</td>
</tr>
</tbody>
</table>

#### ACI Performance Measures (2015 CEHRT)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Performance Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide Patient Access</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Patient-Specific Education</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>View, Download, and Transmit</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Patient-Generated Health Data</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Send a Summary of Care</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Request/Accept a Summary of Care</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Clinical Information Reconciliation</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Immunization Registry Reporting</td>
<td>0 or 10%</td>
</tr>
</tbody>
</table>
### ACI: Composite Score (2017 Transition Year)

#### Base Score

<table>
<thead>
<tr>
<th>Metric</th>
<th>Measure</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security Risk Analysis</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>E-Prescribing</td>
<td>30/250</td>
<td>30/250</td>
</tr>
<tr>
<td>Provide Patient Access</td>
<td>65/250</td>
<td>65/250</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>0/250</td>
<td>1/250</td>
</tr>
<tr>
<td><strong>Base Score</strong></td>
<td>0%</td>
<td>50%</td>
</tr>
</tbody>
</table>

#### Performance Score

<table>
<thead>
<tr>
<th>Metric</th>
<th>Measure</th>
<th>Performance Rate</th>
<th>Percentage Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Reconciliation</td>
<td>125/250</td>
<td>50%</td>
<td>5%</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>250/250</td>
<td>100%</td>
<td>10%</td>
</tr>
<tr>
<td>View, Download, Transmit</td>
<td>53/250</td>
<td>21%</td>
<td>3%</td>
</tr>
<tr>
<td>Patient Access</td>
<td>23/250</td>
<td>9%</td>
<td>2% (worth 20%)</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>48/250</td>
<td>19%</td>
<td>4% (worth 20%)</td>
</tr>
<tr>
<td><strong>Total Performance</strong></td>
<td></td>
<td><strong>24%</strong></td>
<td></td>
</tr>
</tbody>
</table>

*Immunization Registry Reporting*  **10%**

### Key Takeaway: “Direct Messaging” is the Game-Changer
Improvement Activities 15%

➢ Attestation for 90 days

➢ 40 Points = full credit
   ➢ “Medium weight” activities = 10 points
   ➢ “High weight” activities = 20 points

➢ Special scoring for:
   ➢ Groups with <15 Eligible Clinicians
   ➢ Non-patient facing clinicians
   ➢ Rural or Healthcare Professional Shortage Areas (HPSAs)

➢ Full Credit for:
   ➢ Patient-Centered Medical Home or comparable specialty practice
   ➢ Advanced Payment Model
   ➢ MSSP Track 1 ACO
Improvement Activities 15%

- Expanded Practice Access
- Beneficiary Engagement
- Achieving Health Equity
- Population Health Management
- Practice Safety and Assessment
- Integrating Behavioral and Mental Health
- Care Coordination
- Participation in APM
- Emergency Preparedness and Response
Cost 0%

➢ No reporting requirement; Purely scored on claims
➢ CMS will provide feedback on 2017 performance
  ➢ Quality and Resource Use Report (QRUR)
➢ Part B only (for now)

1. Define an episode group
2. Assign cost to episode group
3. Attribute episode groups to responsible clinicians
4. Risk adjust beneficiaries to compare “like patients”
5. Align with quality metrics
Circumstantial Action Steps

“It is not the strongest or the most intelligent who will survive, but those who can best manage change.”

~ Charles Darwin
## Submission Methods

<table>
<thead>
<tr>
<th>Individual</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality</strong></td>
<td><strong>Quality</strong></td>
</tr>
<tr>
<td>➢ QCDR</td>
<td>➢ QCDR</td>
</tr>
<tr>
<td>➢ Qualified Registry</td>
<td>➢ Qualified Registry</td>
</tr>
<tr>
<td>➢ EHR</td>
<td>➢ EHR</td>
</tr>
<tr>
<td>➢ Claims</td>
<td>➢ CMS Web Interface</td>
</tr>
<tr>
<td>➢ CAHPS for MIPS Survey</td>
<td></td>
</tr>
<tr>
<td><strong>Advancing Care Information</strong></td>
<td><strong>Advancing Care Information</strong></td>
</tr>
<tr>
<td>➢ Attestation</td>
<td>➢ Attestation</td>
</tr>
<tr>
<td>➢ QCDR</td>
<td>➢ QCDR</td>
</tr>
<tr>
<td>➢ Qualified Registry</td>
<td>➢ Qualified Registry</td>
</tr>
<tr>
<td>➢ EHR</td>
<td>➢ EHR CMS Web Interface</td>
</tr>
<tr>
<td></td>
<td>(≥25 Eligible Clinicians only)</td>
</tr>
<tr>
<td><strong>Improvement Activities</strong></td>
<td><strong>Improvement Activities</strong></td>
</tr>
<tr>
<td>➢ Attestation</td>
<td>➢ Attestation</td>
</tr>
<tr>
<td>➢ QCDR</td>
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<td>➢ EHR</td>
<td>➢ EHR</td>
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</tbody>
</table>

**Key Takeaway:** Registries generally recognized as preferable route; However, consider cost, available metrics, & manual labor vs. EHR integration.
What can we decide by Friday?

1. Are we Penalty-Avoiders or Incentive-Seekers?
   - 2017, 2018, and beyond...

2. Who is eligible?

3. How will we submit?

4. What is our EHR/registry capable of? When will our EHR upgrade to 2015 CEHRT?

5. Are we actively tracking and comparing our Quality- & ACI- metrics?

6. Who is responsible for which measures? Workflow?

October 1st is your deadline to pursue incentives!
Short Term Solutions

1. Educate your staff…Yes, your entire staff.

2. Crosswalk PQRS and Meaningful Use to MIPS

3. Allocate resources – Build a structure

4. Aim Statement
   - “WHO will achieve WHAT by WHEN by doing WHAT?”

5. Resources:
   - MGMA.com – Member Community “MIPS/APMS: Medicare Value-Based Payment Reform”
   - WWW.QPP.CMS.GOV
   - Transforming Clinical Practice Initiative
   - Quality Improvement Organizations
Long Term Strategy

1. This is not “just another phase”

2. Care coordination, chronic care management, and HIE is the future of healthcare

3. Collaborate
   - “Virtual Groups”
   - Partnerships
   - Clinically Integrate
   - Accountable Care Organization
Remember...
Real World Experience
Common Approaches

➢ Taking on MIPS alone
➢ Joining a group of other independent providers:
  ✓ Independent Physician Association (IPA)
  ✓ Clinically Integrated Network (CIN)
  ✓ Physician Hospital Organization (PHO)
➢ Joining an ACO
Case Study A: IPA / CIN

Original Goals of the IPA:
1) Unified approach with payers
2) Enhanced resources to provide constant education and awareness of today’s market news
3) Dissemination of best practices
4) Group purchase discounts
5) Lab / Ancillary related purchases

➢ FFV Models and MACRA led to the IPA’s Evolution....Forming a Clinically Integrated Network (CIN) entity.
Case Study A: CIN Approach to MIPS

- CIN created in 2015 to provide necessary infrastructure and legal means to coordinate care among independent physicians.
- Members began questioning how such efforts to support a CIN can also help support MIPS compliance and success.
- CIN performed necessary due diligence for MIPS success factors, gaps in current operations, and how MIPS compliance activities and CIN objectives can support one another.
- Research for grant funding that allowed the CIN to take necessary steps as a group, for education and infrastructure otherwise unaffordable and a strain on resources. Focus areas being population health tool, care coordination, and patient engagement.
- CIN requirements remaining include:
  - Legal counsel engagement
  - Clinical workgroups / initiatives
  - Physician engagement
  - Accountability mechanism
Case Study B: PHO to MIPS

➢ Rural health system looking to further collaborate with community physicians and other post acute-care entities. Result – PHO formation.

➢ Entity provided a safeguard and patient outmigration, strengthen position with carriers, and provided physician a larger voice. Furthermore, serves as same structure as CIN’s.

➢ As MIPS came into play, some providers began acting on their own. Confusion, feeling of being overwhelmed, and a sense of lost purpose. Health system provided an anchor for community providers to rally around and tackle MIPS collectively.

➢ Advantages to the PHO include streamlining care coordination with shared resources, further data integration and analytics, and shared patient engagement resources.
MIPS: The Cascade Effect

➢ Case study commonalities – Community providers collaborating with shared interest. MIPS is the core reason, more coordination and open discussions has been the result.
➢ Clinically Integrated Networks (CIN) a common theme and structure of such collaboration.
➢ Key success factors for MIPS and CIN deployment are very similar.
   ✓ Understanding of reporting capabilities and needs
   ✓ Physician engagement
   ✓ Patient engagement
   ✓ Operational and technology infrastructure
➢ And many are selecting CIN affiliation for flexibility and to remain genuinely independent.
➢ Technology and legal fees dominate budgets to deploy new entities.
“Predictions are difficult, especially about the future.”