NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS

MACRA and Value Based Payment Models
Oregon Office of Rural Health

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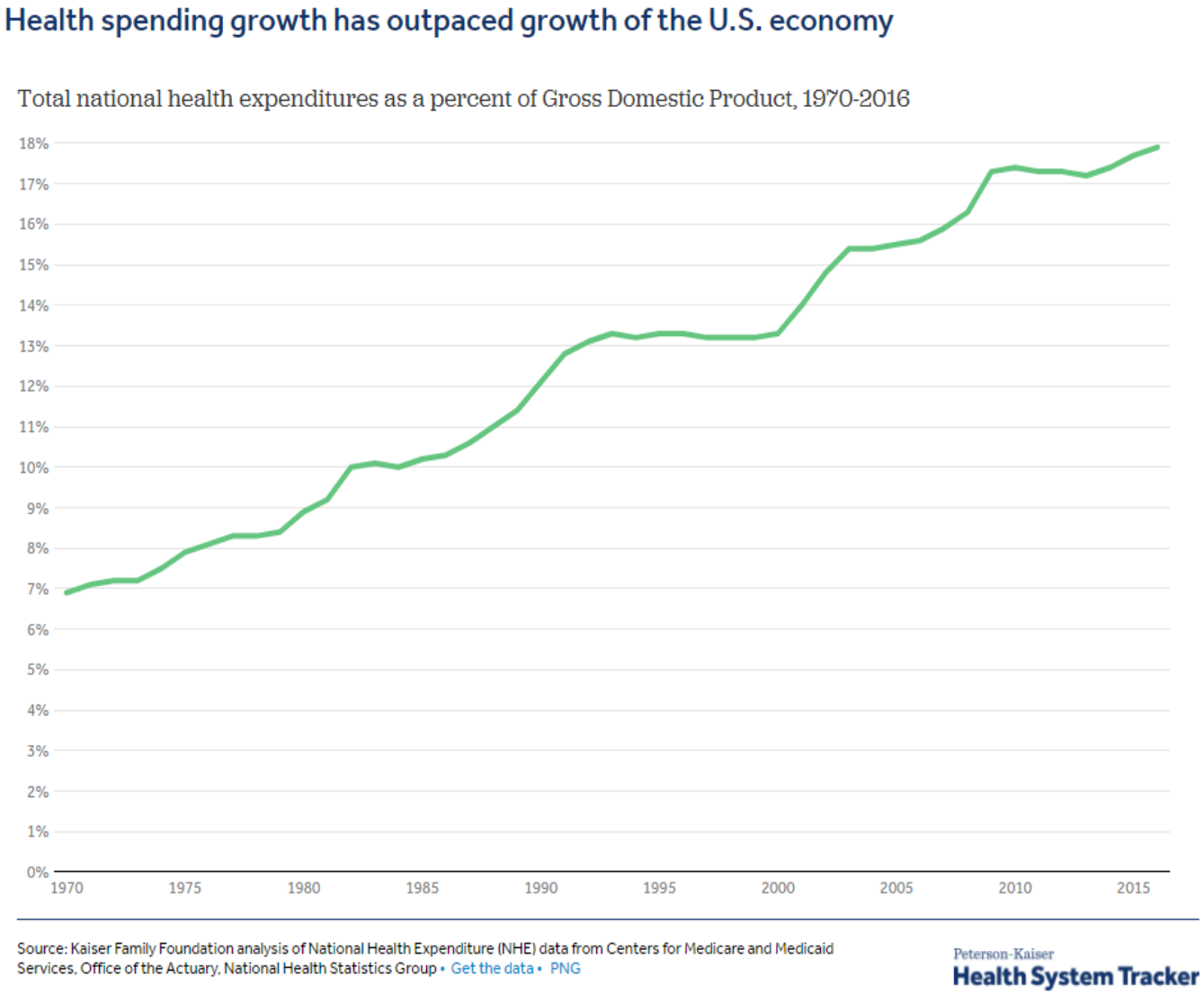
Overview

- Background
  - Sustainable Growth Rate
- MACRA
  - MIPS
  - APMs
- How does this affect RHCs?
- Other value-based models?



Sustainable Growth Rate Formula

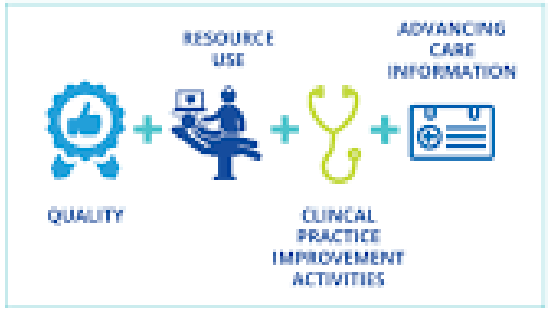
- Enacted by the Balanced Budget Act of 1997
- Goal was to ensure Medicare beneficiary expenses did not exceed GDP growth.
- Worked for a few years
- “Doc-fix” legislation
- Last “doc-fix” prevented 24% reduction in reimbursements to physicians under the PFS
- This year's doc fix bill, which prevents a 24 percent cut in reimbursements to physicians under Medicare, comes despite efforts led by Sen. Ron Wyden (D-Ore.) to broker a bipartisan agreement to permanently scrap the SGR system. "We'll punt, patch it up and let that SGR limp along just as it has year after year," Wyden conceded during a floor speech prior to the vote on Monday. "Every senator that I talked to says that that just defies common sense.“ Wyden voted against the one-year "doc fix" extension.
- https://www.washingtonpost.com/news/post-politics/wp/2014/03/31/for-17th-time-in-11-years-congress-delays-medicare-reimbursement-cuts-as-senate-passes-doc-fix/?utm_term=.563f4a6a0999

MACRA/QPP

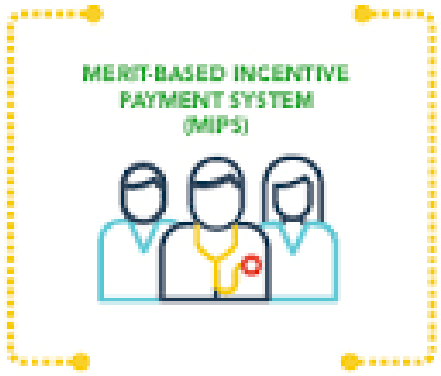
- Medicare Access and CHIP Reauthorization Act
- Repealed the SGR entirely
  - Replaced SGR with two tracks for clinicians:
    - Merit-Based Payment System (MIPS)
    - Advanced Alternative Payment Models (APMs)
  - Collectively referred to as the “Quality Payment Program” or QPP

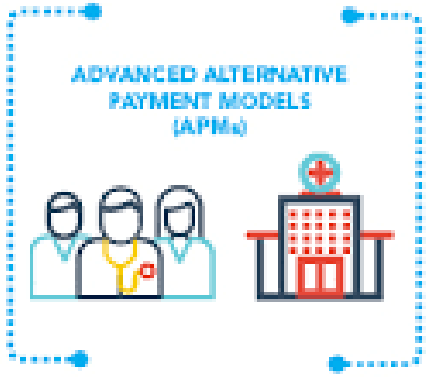
MACRA

MIPS



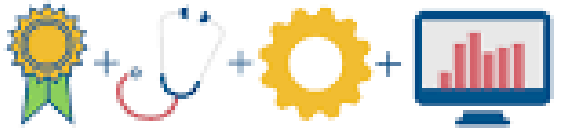
APMs





MACRA/QUALITY PAYMENT PROGRAM (QPP)

MIPS

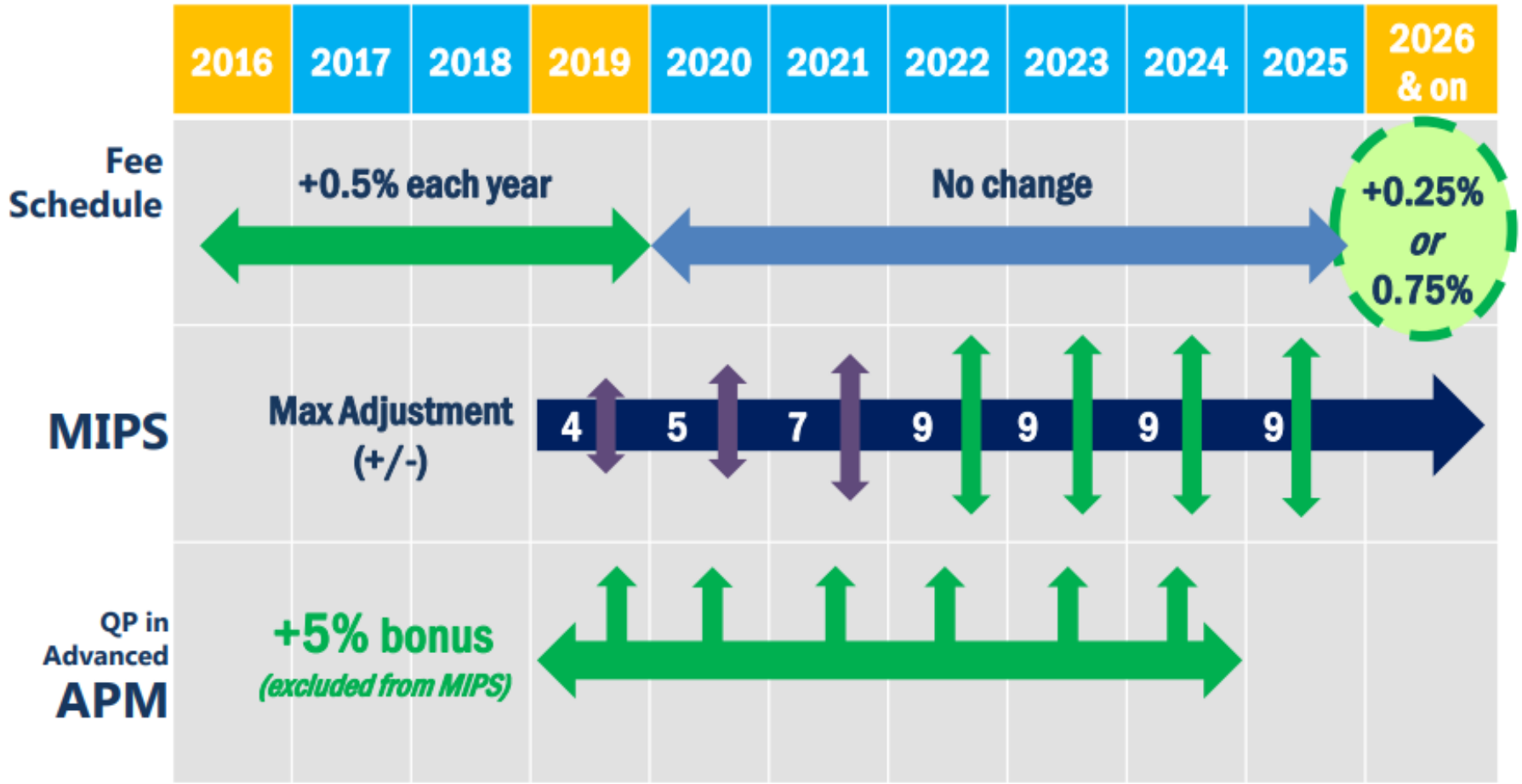


QUALITY | RESOURCE USE | CLINICAL PRACTICE IMPROVEMENT ACTIVITIES | ADVANCING CARE INFORMATION

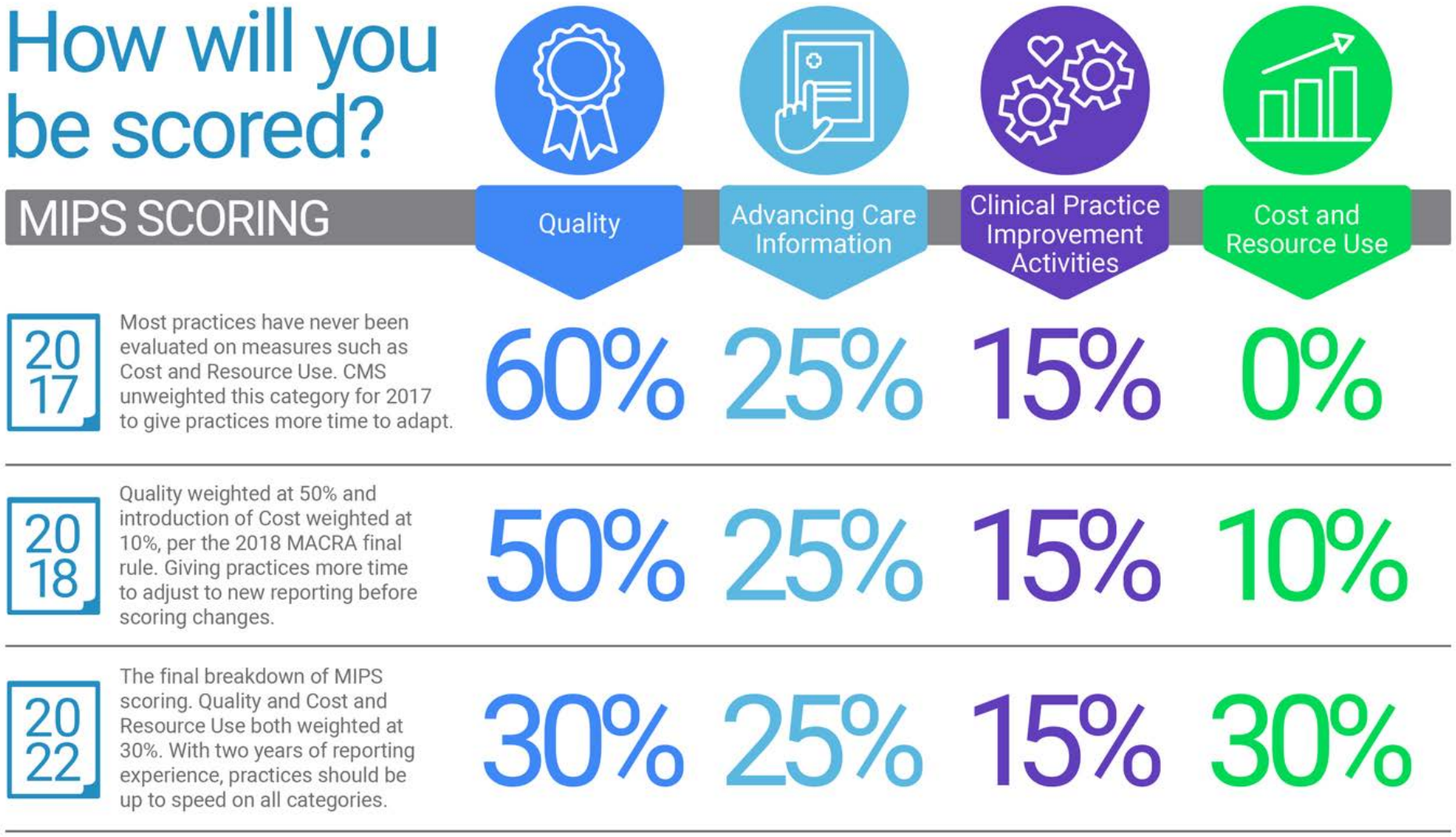
Advanced APMs

ACCOUNTABLE CARE ORGANIZATIONS (ACOS) | BUNDLED PAYMENT MODELS

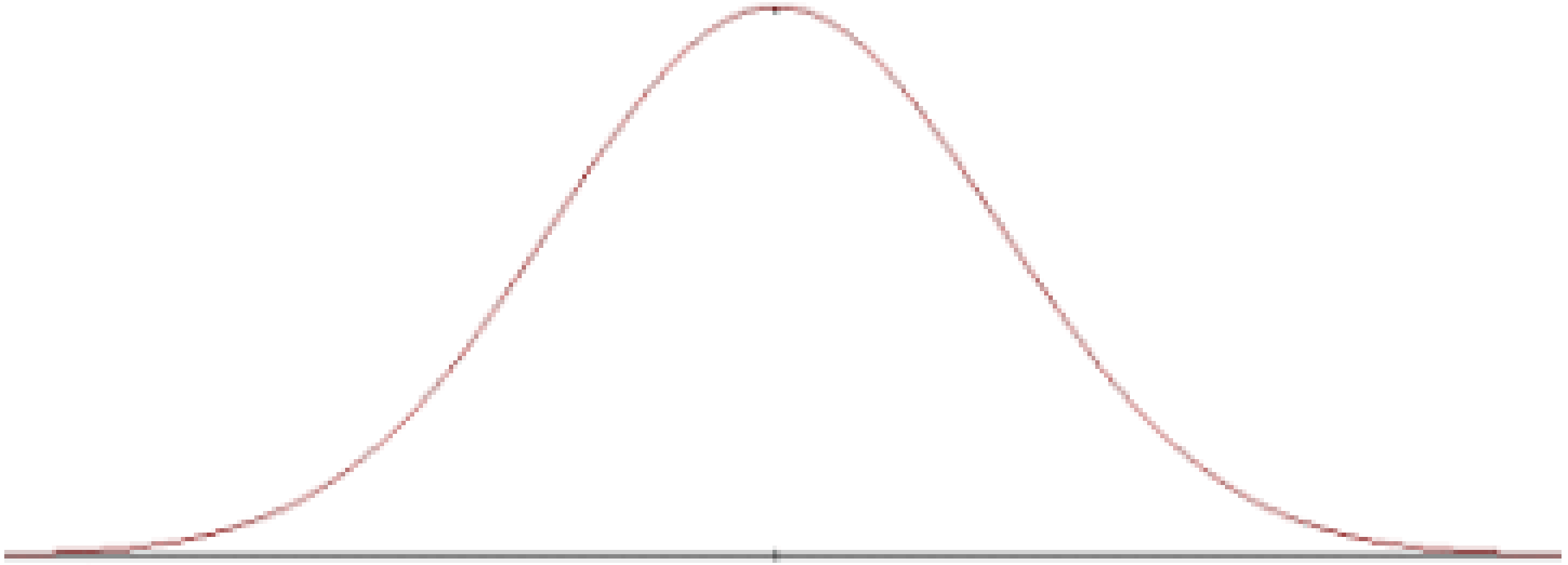
Putting it all together:



What is MIPS?


How will you be scored?
MIPS SCORING
Quality
Advancing Care Information
Clinical Practice Improvement Activities
Cost and Resource Use
2017
Most practices have never been evaluated on measures such as Cost and Resource Use. CMS unweighted this category for 2017 to give practices more time to adapt.
60%
25%
15%
0%
2018
Quality weighted at 50% and introduction of Cost weighted at 10%, per the 2018 MACRA final rule. Giving practices more time to adjust to new reporting before scoring changes.
50%
25%
15%
10%
2022
The final breakdown of MIPS scoring. Quality and Cost and Resource Use both weighted at 30%. With two years of reporting experience, practices should be up to speed on all categories.
30%
25%
15%
30%

What is MIPS?



Quality Measures

- Clinicians pick 6 measures out of 275
  - Clinicians are incentivized to pick the measures where they feel they outperform their peers
- Example:
  - Adult Kidney Disease: Blood Pressure Management
  - Percentage of patient visits for those patients aged 18 years and older with a diagnosis of chronic kidney disease (CKD) (stage 3, 4, or 5, not receiving Renal Replacement Therapy [RRT]) with a blood pressure < 140/90 mmHg OR 140/90 mmHg with a **documented plan of care**

84.7	69.20 - 79.16	79.17 - 90.69	90.70 - 95.08	95.09 - 96.47	96.48 - 97.66	97.67 - 98.73	98.74 - 99.99	100.00

Quality Measures

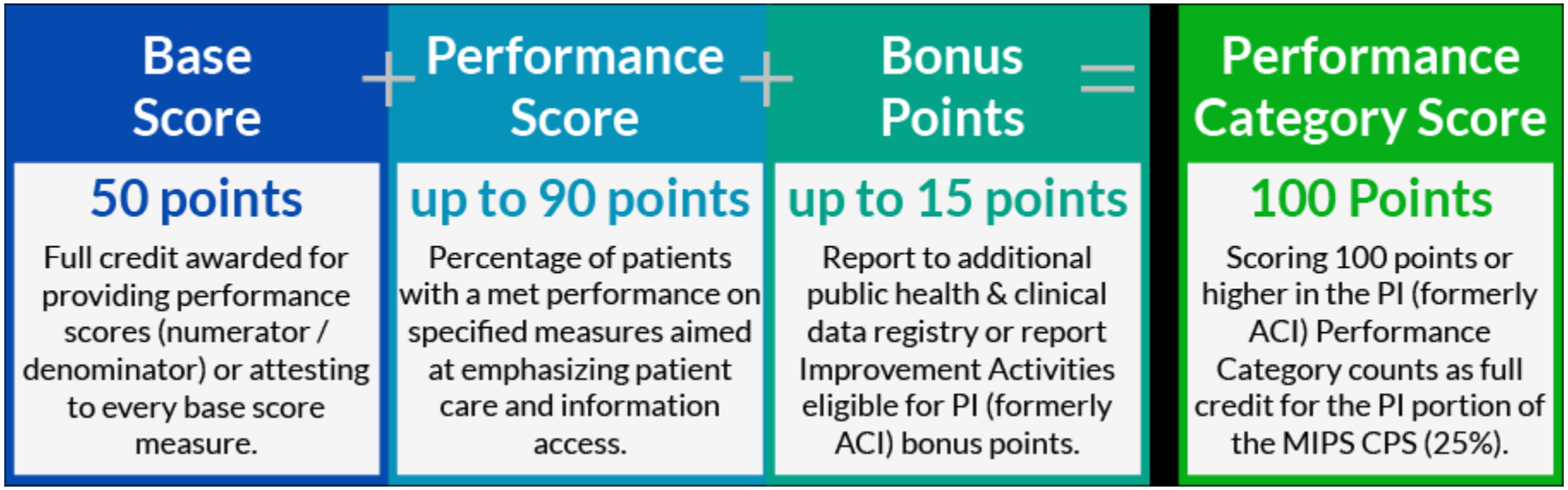
- Another example:
  - Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
  - Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months

96.5	98.99 - 99.99	--	--	--	--	--	--	100.00

Example of a topped out measure.

Cannot get full credit.

ACIP or “Promoting Interoperability”



Promoting Interoperability Base Score Example

- Send a Summary of Care
- For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers their patient to another setting of care or health care provider-(1) creates a summary of care record using certified EHR technology; and (2) electronically exchanges the summary of care record.
  Download

Promoting Interoperability Performance Score Example

- View, Download and Transmit (VDT)
- During the performance period, at least one unique patient (or patient-authorized representatives) seen by the MIPS eligible clinician actively engages with the EHR made accessible by the MIPS eligible clinician. An MIPS eligible clinician may meet the measure by either-(1) view, download or transmit to a third party their health information; or (2) access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the MIPS eligible clinician's certified EHR technology; or (3) a combination of (1) and (2).

Improvement Activities

- Binary
- Should be easy for everyone to get a 100:
  - RHC, IHS or FQHC quality improvement activities
  - Participating in a Rural Health Clinic (RHC), Indian Health Service Medium Management (IHS), or Federally Qualified Health Center in ongoing engagement activities that contribute to more formal quality reporting , and that include receiving quality data back for broader quality improvement and benchmarking improvement which will ultimately benefit patients. Participation in Indian Health Service, as an improvement activity, requires MIPS eligible clinicians and groups to deliver care to federally recognized American Indian and Alaska Native populations in the U.S. and in the course of that care implement continuous clinical practice improvement including reporting data on quality of services being provided and receiving feedback to make improvements over time.

  - Engagement of New Medicaid Patients and Follow-up
  - Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare. A timely manner is defined as within 10 business days for this activity.

Cost Measures

- Medicare Spending Per Beneficiary (MSPB)
- The Medicare Spending Per Beneficiary (MSPB) measure evaluates solo practitioners and groups on their spending efficiency and is specialty-adjusted to account for their specialty mix. Solo practitioners and groups are identified by their National Provider Identification (NPI) and Taxpayer Identification Number (TIN) combination. Specifically, the MSPB measure assesses the average spend for Medicare services performed by providers/groups per episode of care. Each episode comprises the period immediately prior to, during, and following a patient's hospital stay.
- Total Per Capita Costs (TPCC)
- The Total Per Capita Costs (TPCC) measure is a payment-standardized, annualized, risk-adjusted, and specialty-adjusted measure that evaluates the overall efficiency of care provided to beneficiaries attributed to solo practitioners and groups, as identified by their Medicare Taxpayer Identification Number (TIN)

Composite Performance Score

- Each category is evaluated and then each eligible clinician receives a “composite performance score”
- The number that matters in terms of penalties/bonuses

Transition Years and Performance Threshold

- First year, the performance threshold was set at 3
- Second year, threshold was set at 15
- Proposed for the year 3: threshold of 30
  - Initially there was only supposed to be 2 transition years.
  - The Bipartisan Budget of Act of 2018 (passed in Feb.) extended this another 3 years. So the transitional period will now last through the 2023 payment year.
- Where would the performance threshold be if the transitional period had not been extended?
  - When we analyzed the estimated final scores for the 2019 MIPS payment year, the mean final score was between 63.50 and 68.98 points and the median was between 77.83 and 82.5 points based on the different participation assumptions.

Eligible Clinicians

- When MACRA first passed, most eligible clinicians would be required to participate in MIPS or APMs
- Since the law passed there have been several regulatory changes to make the program optional for most clinicians
- RHC services are not paid under the physician fee schedule and thus not affected
- CMS estimates that 218k clinicians have “required eligibility”
- 389k have group eligibility
- 42k will “opt in”
- 482k will “opt out”
- 88k are not eligible because of low volume threshold (RHCs fit here)
- 302k are excluded for other reasons

Low Volume Threshold ~ Proposed rule

- Specifically, we request comments on our proposal, for the 2021 MIPS payment year and future years, that eligible clinicians or groups who meet at least one of the following three criteria during the MIPS determination period would not exceed the low-volume threshold: (1) Those who have allowed charges for covered professional services less than or equal to $90,000; (2) those who provide covered professional services to 200 or fewer Part B-enrolled individuals; or (3) those who provide 200 or fewer covered professional services to Part B-enrolled individuals.

Advanced APMs ~ Requirements

- Requires its participants to use certified EHR technology (CEHRT) (81 FR 77409 through 77414);
- Provides for payment for covered professional services based on quality measures comparable to measures under the quality performance category under MIPS (81 FR 77414 through 77418); and
- Either requires its participating APM Entities to bear financial risk for monetary losses that are in excess of a nominal amount, or is a Medical Home Model expanded under section 1115A(c) of the Act (81 FR 77418through 77431). We refer to this criterion as the financial risk criterion.

Advanced APMs ~ Incentives

- Beginning in 2019, if an eligible clinician participated sufficiently in an Advanced APM during the QP Performance Period, that eligible clinician may become a QP for the year. Eligible clinicians who are QPs are excluded from the MIPS reporting requirements for the performance year and payment adjustment for the payment year.
- For years from 2019 through 2024, QPs receive a lump sum incentive payment equal to **5 percent of their prior year's estimated aggregate payments for Part B covered professional services**. Beginning in 2026, QPs receive a higher update under the PFS for the year than non-QPs.
- For payment years 2019 and 2020, eligible clinicians may become QPs only through participation in Advanced APMs.
- For payment years 2021 and later, eligible clinicians may become QPs through a combination of participation in Advanced APMs and Other Payer Advanced APMs (which we refer to as the All-Payer Combination Option).

Advanced APMs

2018 APM Information

What models are Advanced APMs?

In Performance Year 2018, the following models are Advanced APMs:

- UPDATED Bundled Payments for Care Improvement Advanced Model (BPCI Advanced)
- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- UPDATED Medicare Accountable Care Organization (ACO) Track 1+ Model
- Next Generation ACO Model
- Shared Savings Program - Track 2
- Shared Savings Program - Track 3
- Oncology Care Model (OCM) - Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT)

Is anyone in an Advanced APM?

- What has changed?
- What benefits have their been?
  - Financial benefits?
- Are there any downsides?
- Would patients notice any changes?

Outlook of MACRA

- Voted 14-2 to recommend a repeal of MIPS and replacing it with a new “Voluntary Value Program”
- Advanced APMs have had mixed results
- Proponents and Opponents of “ACOs” and Medicare Shared Saving Program can manipulate the data to support their position.

What does this all mean for RHCs?

- By and large because RHCs are paid on a cost-basis through an All-Inclusive Rate, Medicare quality initiatives have not affected RHCs
- States and private payers may have other quality initiatives that do affect RHCs (PCMH etc.)
- When “value” or “quality” comes to the RHC program, what will it look like?

Questions?

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