TODAY’S WEBINAR

• **Together 2 Goal® Updates**
  – Webinar Reminders
  – Goal Post February Newsletter Highlights
    • Upcoming Dates
    • Campaign Spotlight: Together 2 Goal® Diabetes Symposium
    • Resource of the Month: AMGA 2017 Annual Conference

• **Diabetes & MACRA**
  – Darryl M. Drevna, AMGA's Director of Regulatory and Public Policy

• **Q&A**
  – Use Q&A or chat feature
WEBINAR REMINDERS

• Webinar will be recorded today and available the week of February 20th
  – Together2Goal.org Website (Improve Patient Outcomes → Webinars)
  – Email distribution

• Participants are encouraged to ask questions using the “Chat” and “Q&A” functions on the right side of your screen
Upcoming Dates

- **March 1**: Q4 2016 data submission due
- **March 16**: Monthly campaign webinar (Minimally Disruptive Medicine & Diabetes)
- **March 22-25**: AMGA 2017 Annual Conference
Upcoming Dates

- **AMGA 2017 Annual Conference**
  - Agenda, registration, and more information available at www.amga.org/AC17
  - Together 2 Goal® sessions include:
    - Improving Care Delivery: Assessing and Addressing the Risk of Cardiovascular Disease for Patients with Diabetes (Premier Medical Associates)
    - Partnering for Improved Health: Excela Health’s Implementation Journey (Excela Health Medical Group)
GOAL POST NEWSLETTER: FEBRUARY HIGHLIGHTS

Campaign Spotlight

• Together 2 Goal® Diabetes Symposium
  – In collaboration with the American Diabetes Association
  – September 12-13 in Indianapolis
  – In conjunction with:
    • Chronic Care Roundtable (September 11-12)
    • AMGA Analytics’ A4i learning collaborative meeting (September 12-13)
    • AMGA’s Chief Medical Officer/Medical Director, Chief Nursing Officer & Quality Leadership Council meetings (September 13-15)
Improving Diabetes Screening and Referral to Prevention Programs: A Healthy People 2020 Spotlight on Health

- Webinar will highlight:
  - The U.S. Preventive Services Task Force recommendation on blood glucose and Type 2 diabetes screening
  - Provider referral to evidence-based diabetes prevention programs
  - Medicare’s focus on diabetes prevention programs

- February 21 from 12:30 p.m. – 2:00 p.m.

- To register, visit healthypeople.gov
TODAY’S SPEAKER

Darryl M. Drevna
Director of Regulatory and Public Policy
AMGA
MACRA and Diabetes

February 16, 2017

Darryl M. Drevna, M.A.
Director, Regulatory and Public Policy
AMGA
Presentation Outline

Medicare Access and CHIP Reauthorization Act (MACRA)

Legislative History

Merit-Based Incentive Payment System (MIPS)

Eligible Clinicians (ECs) and Exemptions

MIPS Reporting and Performance Categories

Diabetes Measures and Improvement Activities

Advanced Alternative Payment Models (APMs)

2017 Performance Year Models

Patient and Payment Thresholds

Obstacles and Challenges
Medicare Access and CHIP Reauthorization Act (MACRA)

- MACRA became law April 16, 2015 (the bill passed with overwhelming Congressional support, i.e., received over 90% of Senate and House votes)

- MACRA Title 1 sunsets and replaces the SGR annual physician (and other eligible professionals) fee update methodology

- MACRA creates what CMS terms the “Quality Payment Program”

- The law establishes a 0.5% annual physician fee update in the short-term, from 2015 and through 2019
MACRA: Two Pathways

SGR → MACRA

MIPS

APMs
MACRA: Merit-Based Incentive Payment System

Performance Year begins in 2017

Quality
Resource Use
Clinical Practice Improvement Activities
Advancing Care Information
MIPS: Eligible Clinicians (ECs)

Years 1 – 2 (2017-2018)
- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists

Potential additional ECs (2019+)
- Physical or Occupational Therapists
- Speech Language Pathologists
- Audiologists
- Nurse Midwives
- Clinical Social Workers
- Clinical Pathologists
- Clinical Psychologists
- Dietitians/Nutritional Professionals
MIPS Exclusions

- Total Part B ECs estimated at approximately 750,000
- ECs who fall below low volume Medicare threshold
  - ($30,000 OR less than 101 beneficiaries annually)
- CMS estimates 32.5% or 380,000 to be excluded
- First year Medicare ECs
- APM qualifying/partially qualifying participants
  - 70,000 – 120,000 expected in 2017
MIPS Performance Categories
MIPS: Four Components

- Increased quality weight in 2017 from 50% to 60%
- Renamed proposed “Clinical Practice Improvement Activities” to “Improvement Activities”
- Renamed “Resource Use” to “Cost” and delayed until performance year 2018
MIPS: Minimum Participation

To avoid a negative update in 2019

During the 2017 performance year:

Report 1 quality measure OR
Report 1 improvement activity OR
Report all 5 ACI base measures

What happens in 2018?
MIPS: Quality Measures Reporting Full Participation

6 quality measures or specialty/sub-specialty measure set

- All Cause Hospital Admission (ACHA) for Groups of 16 or more
- Groups of 25+: GPRO on first 248 beneficiaries
- 1 Outcome Measure or “High Priority” if outcome unavailable
- Proposed Cross-Cutting Measure not finalized
Diabetes Quality Measures

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
- Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period (T2G is >8%)

Diabetes: Medical Attention for Nephropathy
- The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.

Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
- Percentage of the patients considered at high risk of cardiovascular events who were prescribed or were on statin therapy during the measurement period

https://qpp.cms.gov/measures/quality
Other Diabetes Quality Measures

- Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
- Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
- Diabetes: Eye Exam
- Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation
- Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear

https://qpp.cms.gov/measures/quality
MIPS: Quality Measures Scoring

For 2017 Performance Period

- 60% weight in 2017, 50% in 2018, 30% in 2019 performance years
- Total of 60 or 70 points possible: measures are scored between 1 and 10 points (in deciles)
- Bonus points are available for outcome and patient experience measures
- If an insufficient number of quality measures are reported, scores will re-weight ACI and Improvement Activities
- Separate benchmarks for EHR, QCRD, Qualified Registry, Claims, GPRO
- Topped out measures (half of measures are topped out) for 2017 scored same as all other quality measures
- MIPS APMs (ACOs) are scored based on MSSP quality reporting
MIPS: Improvement Activities Reporting

Attest completion of minimum of 4 activities for 90 days

Rural or Small Practice: Attest 2 activities for 90 days

Full Credit for PCMH

Half Credit for other APMs

15% Weight (2017)

Expanded Care Access

Care Coordination

Population Management

Beneficiary Engagement

Patient Safety and Practice Assessment

Achieving Health Equity

Emergency Preparedness and Response

Integrated Behavior and Mental Health
Diabetes Improvement Activities Measures

- For outpatient Medicare beneficiaries with diabetes and who are prescribed antidiabetic agents (e.g., insulin, sulfonylureas), MIPS eligible clinicians and groups must attest to having: For the first performance year, at least 60 percent of medical records with documentation of an individualized glycemic treatment.

- Develop pathways to neighborhood/community-based resources to support patient health goals that could include one or more of the following:

  - Maintain formal (referral) links to community-based chronic disease self-management support programs, exercise programs and other wellness resources with the potential for bidirectional flow of information; and/or
  - Provide a guide to available community resources.

- Provide condition-specific chronic disease self-management support programs or coaching or link patients to those programs in the community.

- Provide self-management materials at an appropriate literacy level and in an appropriate language.

- Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities Integrate practice change/quality improvement into staff duties;

  https://qpp.cms.gov/measures/ia
Other Diabetes Improvement Activities

- Diabetes screening for people with schizophrenia or bipolar disease who are using antipsychotic medication
- As a result of Quality Innovation Network-Quality Improvement Organization technical assistance, performance of additional activities that improve access to services (e.g., investment of on-site diabetes educator)
- Use group visits for common chronic conditions (e.g., diabetes)
- Proactively manage chronic and preventive care for empaneled patients

https://qpp.cms.gov/measures/ia
MIPS: Improvement Activities Scoring

• Total of 40 points possible for reporting improvement activities
• Each activity is weighted either “high” or “medium”
  • High weighted activities earn 20 points
  • Medium weighted activities earn 10 points
  • Presently cannot measure variable performance
• “Full credit” or 40 points awarded to
  • Certified Patient-Centered Medical Home
• “Half credit” awarded to other APMs
• For small, rural and HPSAs report 2 medium or 1 high improvement activity for “full credit” ($100 million is budgeted for technical assistance)
MIPS: Advancing Care Information Reporting

Has base and performance reporting components

Final rule reduced required “base” measures from 11 to 5

9 performance measures

2015 CEHRT required to report in the ACI category in 2018

90-day performance period (reduction from full year)
MIPS: Advancing Care Information Scoring

ACI is 25% of composite performance score

Performance period of 90 days: full year encouraged

Base score:

• Pass/Fail: must report on all measures in the base score (50% of total ACI score)
• Reporting the numerator and denominator for each required measure
• Attestation reporting method

Performance score:

• Must first report 5 base measures to earn any ACI score
• 9 total performance measures available

  Must meet protect patient health information requirement.

  Failure to do so results in a score of 0
MIPS: Cost

0% in 2017
10% in 2018
30% in 2019
MIPS: Cost Scoring

• Cost scoring replaces Value-Based Modifier
• Reporting is claims based – no reporting requirement
• The benchmark is the performance period
• The benchmark is national not regional
• CMS will forward for informational purposes per capita costs (minimum 20 cases) and Medicare spending per beneficiary (MSPP) (minimum 35 cases)
MIPS: Calculating the Composite Performance Score (CPS)

Quality
60% and 60-70 Points

Advancing Care Information
25% and 100+ Points

Improvement Activities
15% and 40 Points

Cost
0%

CPS threshold for 2017 is 3 points
MIPS: Budget Neutral

Clinicians will receive annual adjustments beginning payment year 2019
Neutral, Positive, or Negative (Standard Distribution)

2019: 4%
2020: 5%
2021: 7%
2022 and Beyond: 9%

Scaling Factor of 3x may apply to positive adjustment to ensure budget neutrality

Scaling factor does not apply to negative adjustments
MIPS: Exceptional Performance Bonus

• $500 million available each year from 2019 – 2024 for those with exception performance

• Exceptional performance threshold is 70 points for performance year 2017

• Limited to stop-gain restrictions

Exceptional threshold: 70 points

A share of $500 million
MIPS: “Pick Your Pace” Payment Adjustment

2017 performance determines 2019 payment adjustment

1. Submit no data = -4% update
2. One quality measure OR one improvement activity OR the required advancing care information measures: neutral or positive MIPS update
   1) If reporting via GPRO must meet case minimum requirements
3. More than one quality measure, OR more than one improvement activity, OR advancing care information base measures: positive update possible, avoid negative update

(Medicare physician fee schedule updated 0.5% from 2015-2019)
## MIPS: Original Estimate

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<th>Size</th>
<th>% Positive</th>
<th>% Negative</th>
<th>Aggregate Positive</th>
<th>Aggregate Negative</th>
<th>Aggregate $500 M</th>
<th>Net</th>
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<td>$65</td>
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<td>-$101</td>
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<td>18.3%</td>
<td>$336</td>
<td>-$57</td>
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Aggregate Positive/Neutral = $833

Aggregate Negative = -$833

Figures in Millions
MIPS: Budget Neutral

90% est. to receive positive or neutral MIPS payment adjustment

90% of practices w/ 1-9 clinicians est. to receive positive or neutral payment adjustment

CMS “Flattening the Curve”: score distribution will be more limited

<table>
<thead>
<tr>
<th>Size</th>
<th>% Positive/Neutral</th>
<th>% Negative</th>
<th>Aggregate Positive/Neutral</th>
<th>Aggregate Negative</th>
<th>Aggregate $500 M</th>
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<td>1.5%</td>
<td>$72</td>
<td>-$16</td>
<td>$202</td>
<td>$258</td>
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Figures in Millions
Alternative Payment Models (APMs)

- MIPS APMs (No 5% Bonus)
- Partially-Qualifying APMs (No 5% Bonus & MIPS Choice)
- Advanced APMs (5% Bonus)
Advanced APM Requirements

- Be a CMS Innovation Center model
- Use Certified EHR Technology (CEHRT)
  - For 2017 50% of QPs would need to use CEHRT
- Base payments for services on quality measures comparable to those in MIPS
- Be a Medical Home expanded under Medicare Innovation Center OR require participants to “bear more than nominal financial risk for losses”
- ECs will be notified of their APM status before the end of the performance year
- CMS will take three “snapshots” during the performance period: March 31, June 30, and August 31 to identify qualifying participants (QPs) – not only at December 31 as proposed
CMS “Pre-Approved” Advanced APMs

2017 Performance Year

- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- 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)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

Updated on an ad hoc basis – will not go through formal rulemaking process

2018 Performance Year and beyond

- ACO Track 1+
- Episode (bundled) payment models to be determined
Advanced APM Thresholds (2019+)

Qualifying Payment Threshold

- 2019-2020: 25%
- 2021-2022: 50%
- 2023+: 75%

Qualifying Beneficiary Threshold

- 2019-2020: 20%
- 2021-2022: 35%
- 2023+: 50%

Quality Measures and CEHRT

- Measures similar to MIPS
- Certified Electronic Health Records Technology

Beneficiaries defined as “eligible” not “assigned”

Payment and patient determinations are determined from January 1 – August 1 of the performance year

Medicare only option for 2017 and 2018

See table 32 in final rule
Partially Qualifying Medicare Thresholds

**Partially-Qualifying Payment Threshold**

- **2019-2020:** 10%
- **2021-2022:** 25%
- **2023+:** 50%

**Partially-Qualifying Beneficiary Threshold**

- **2019-2020:** 10%
- **2021-2022:** 25%
- **2023+:** 35%

Do not meet revenue or patient thresholds for Advanced APMs

CMS lowered partially-qualifying payment threshold

Can choose whether to report under MIPS

Those who report subject to all MIPS requirements and would receive a MIPS payment adjustment

Does not qualify for 5% Advanced APM bonus
APMs: Bonus Payments

- 5% of aggregate amounts paid for Medicare Part B professional services from proceeding year across all billing TINS associated with the QPs NPI
- Payment made no later than 1 year from end of the incentive payment base period (as soon as 6 months possible)
- Payment made to QP’s TIN. Multiple TINs will split payment proportionally
- CMS estimates $333 million to $571 million in Advanced APM bonus payments in 2019
Obstacles and Challenges

- Immature Risk Market: Lack of access to commercial value-based products make it difficult to achieve Advanced APM status
- Lack of Access to Claims Data: Administrative claims data needed to manage quality and costs
- Non-standard data: Data submitted in different formats, creating an administrative burden
- Limited Access to Capital: Investments in the infrastructure needed are delay
- Inadequate infrastructure: Necessary infrastructure is expensive and difficult to implement
Preparing for 2018

- CMS expects to increase the number of required outcome quality measures.
- The weight for the cost performance category is expected to increase to 10%.
- CMS may add additional episode-based cost measures.
- For performance periods occurring in 2018, CMS finalized a 60% data completeness threshold for claims, registry, QCDR, and EHR submission mechanisms (up from 50%).
- CMS will modify the benchmark methodology for topped out measures beginning with the CY 2018 performance period.
- CMS expects 70,000 to 120,000 clinicians will become QPs in 2017. This is expected to increase to 125,000 to 250,000 clinicians in 2018.
- PQRS, VM, and Medicare EHR Incentive Program for FFS EPs will “end” in 2018.
Thank You

Questions/Comments

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