Katina Nicolacakis, MD, FCCP, is a physician in the Pulmonary Department of the Respiratory Institute at Cleveland Clinic. She is a diplomat in pulmonary, and critical care medicine of the American Board of Internal Medicine and has practiced general pulmonary and critical care medicine in the Cleveland area her entire career post fellowship. She is also an Assistant Professor of Medicine at the Cleveland Clinic’s Lerner College of Medicine of Case Western Reserve University and has been on the faculty of CWRU for over 20 years. She has worked in a variety of practice settings including private practice and academic institutions. Her varied experience lead to proficiency in the realm of professional reimbursement and practice management. As a result, she is one of a small number of physicians in the nation who work with the pulmonary societies (American Thoracic Society and American College of Chest Physicians or CHEST) in the area of practice management, payment policy and the medical reimbursement. She is a long standing member of the ATS Clinical Practice Committee and a past Chair, as well as an Advisor for the ATS to the AMA Relative Value Scale Update Committee (RUC). At Cleveland Clinic, she serves as the Director for Medical Compliance, Billing and Reimbursement for the Respiratory Institute and uses this role to work with the Respiratory Institute administrative team to improve documentation, enhance revenue and maintain regulatory compliance for the Institute’s nearly 200 clinicians. Outside of medicine, she enjoys her role as spouse and mother of 2 as well as perfecting her skills in cooking traditional Greek cuisine from her parent’s birth island of Crete. She also enjoys traveling there as often as possible to maintain her connection with extended family.

OBJECTIVES:
Participants should be better able to:

1. Describe the Medicare Access and CHIP Reauthorization Act of 2015 and the new Quality Payment Program;
2. Describe the Merit Based Incentive Payment System and its components;
3. Review the Advanced Alternative Payment Model requirements;
4. Review the Quality Payment Program Year 2 changes.
Disclaimer

- No Conflicts/Disclosures
- Opinions rendered are my own.
- ATS Relative Value Update Committee (RUC) Advisor to the AMA.
- ATS Clinical Practice Committee, Past-Chair and Advisory Board Member to, ATS Coding and Billing Quarterly newsletter
- No warranty or guarantee of fitness is made or implied.
Objectives

• Describe the Medicare Access and CHIP Reauthorization Act of 2015 and the new Quality Payment Program
• Describe the Merit Based Incentive Payment System and its components
• Review the Advanced Alternative Payment Model requirements
• Review the Quality Payment Program Year 2 changes

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Medicare Payment Prior to MACRA
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

**Fee-for-service** (FFS) payment system, where clinicians are paid based on **volume** of services, not **value**.

**The Sustainable Growth Rate (SGR)**
- Established in 1997 to control the cost of Medicare payments to physicians

**IF**
- Overall physician costs > Target Medicare expenditures

**THEN**
- Physician payments cut across the board

Each year, Congress passed temporary “doc fixes” to avert cuts (no fix in 2015 would have meant a 21% cut in Medicare payments to clinicians)

Changes the way that Medicare rewards clinicians for **value over volume**

[https://qpp.cms.gov](https://qpp.cms.gov)
The Quality Payment Program (QPP)

- Centers for Medicare & Medicaid Services (CMS)
- Medicare Access and CHIP Reauthorization Act (MACRA)
- Merit-Based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (Advanced APMs or AAPMs)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) for the Merit-based Incentive Payment System (MIPS) Survey
- Tax Identification Number (TIN)
- National Provider Identifier (NPI)
- Medicare Physician Fee Schedule (MPFS)
- Medicare Physician Quality Reporting System (PQRS)
- Medicare Quality and Resource Use Report (QRUR)
- Certified Electronic Health Record Technology (CEHRT)
- Patient-Centered Medical Home (PCMH)
MACRA - 2 Pathways

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- Merit-Based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (APMs)

Quality Payment Program
Two Tracks…

Providers must decide how they will participate in Medicare programs 2017 and beyond

- Track 1: MIPS
  Increased emphasis on quality measures

- Track 2: APM
  Risk based payment methodologies

Or
Quality Payment Program Timeline

- 2017 Performance Year
- March 31, 2018 Data Submission
- Feedback
- January 1, 2019 Payment Adjustment

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Merit-based Incentive Payment System
MIPS Replaces 3 Incentive Programs
2019 Payments, Based Upon 2017 Reporting

- Physician Quality Reporting Program (PQRS)
- Value-Based Payment Modifier (quality & cost of care)
- "Meaningful use" of EHRs

Merit-Based Incentive Payment System (MIPS)
2017 Transition year score

The Merit-based Incentive Payment System Calculates a Performance Score

<table>
<thead>
<tr>
<th>Transition Year Weights</th>
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<tr>
<td>Quality</td>
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<tr>
<td>60%</td>
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www.qpp.cms.gov
Which Qualified Practitioners can participate in MIPS in 2018?

A. Speech language pathologists
B. Certified registered nurse anesthetists
C. Registered respiratory therapists
D. Physical therapists
Who is Included in MIPS?

- Physicians **
- Physician Assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists

** includes MD, DO, Dentists, Podiatrists, Optometrists, Chiropractors

Who is Excluded from MIPS in Year 2?

- Newly Enrolled in Medicare (first year)
- Significantly participating in Advanced Alternative Payment Models
  - Receive 25% of Medicare Payments from Advanced Alternative Payment Models
  - See 20% of Medicare patients from Advanced Alternative Payment Models
- Those who don’t meet the low volume threshold - < $90,000 Medicare Part B or < 200 Part B patients/year
Final Deadlines

“Pick your Pace” Data Submission

No data submission in 2017 = 4% deducted from your Medicare Payments in 2019

www.qpp.cms.gov
What is the Maximum bonus/penalty possible for 2021

A. 2%
B. 4%
C. 5%
D. 7%
Timeline of Incentive/Penalty Payments

The cycle of the program looks like this:

2017 2018 2019 2020 2021 2022
±4% ±5% ±7% ±9%

Data Reporting: Individual vs Group

**Individual**
- Single NPI tied to a single Taxpayer ID Number (TIN)
- Quality data can be sent through Medicare Claims Process

**Group**
- 2 or more Clinicians sharing a common TIN
- If Clinicians participate as a group, then they are assessed as a group across all 4 categories
## Data Reporting Methods

### Individual
- Electronic Health Record
- Qualified Clinical Data Registry (QCDR)
- Qualified Registry
- Quality Data via Claims
- Attestation an option for Advancing Care Info and for Improvement Activities

### Group
- Electronic Health Record
- QCDR
- Qualified Registry
- CMS Web Interface (> 25 in group) Register by 6/30/17
- Attestation an option for Advancing Care Info and for Improvement Activities

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## The Merit-based Incentive Payment System Calculates a Performance Score

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<td><strong>Quality</strong> 60%</td>
</tr>
<tr>
<td><strong>Cost</strong> 0%</td>
</tr>
<tr>
<td><strong>Improvement Activities</strong> 15%</td>
</tr>
<tr>
<td><strong>Advancing Care Information</strong> 25%</td>
</tr>
</tbody>
</table>

www.qpp.cms.gov
Quality Measures Replace “Physician Quality Reporting System” (PQRS)

- COPD-Long Acting Bronchodilator FEV1 60% predicted
- COPD-Spirometry Evaluation
- Medication management for Persistent Asthma
- Optimal Asthma Control (Outcome Measure)
- Prevention of Central line infections

https://qpp.cms.gov/measures/quality

About 300 Quality Measures

- Sleep Apnea-Assessment of positive airway pressure (PAP) compliance
- Sleep Apnea- Assessment of Sleep Symptoms
- Sleep Apnea- PAP Therapy Prescribed
- Moderate to Severe OSA
- Sleep Apnea –Severity Assessment (AHI or RDI) at Initial Diagnosis

https://qpp.cms.gov/measures/quality
2017 is “Benchmarking Year”

• Earn 3 to 10 points per Quality Measure
• Based on Performance against Benchmarks

<table>
<thead>
<tr>
<th>Decile</th>
<th>Number of Points Assigned for the 2017 MIPS Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below Decile 3</td>
<td>3 points</td>
</tr>
<tr>
<td>Decile 3</td>
<td>3-3.9 points</td>
</tr>
<tr>
<td>Decile 4</td>
<td>4-4.9 points</td>
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<tr>
<td>Decile 5</td>
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</tr>
<tr>
<td>Decile 7</td>
<td>7-7.9 points</td>
</tr>
<tr>
<td>Decile 8</td>
<td>8-8.9 points</td>
</tr>
<tr>
<td>Decile 9</td>
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</tr>
<tr>
<td>Decile 10</td>
<td>10 points</td>
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The Merit-based Incentive Payment System Calculates a Performance Score

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www.qpp.cms.gov
Clinical Practice Improvement - 15% of MIPS

- Review list of current Improvement Activities (>90 CPIAs under 9 subcategories):
  - Expanded Practice Access
  - Population Management
  - Care Coordination
  - Patient Engagement
  - Patient Safety And Practice Assessment
  - Participation In An APM
  - Achieving Health Equity
  - Emergency Preparedness And Response
  - Integrated Behavioral And Mental Health
- Align existing activities with MIPS required Improvement Activities.
- Physicians who participate in a nationally recognized, accredited patient-centered medical home will automatically receive full CPIA credit.

https://qpp.cms.gov/measures/ia

The Merit-based Incentive Payment System Calculates a Performance Score

Transition Year Weights

- Quality: 60%
- Cost: 0%
- Improvement Activities: 15%
- Advancing Care Information: 25%

www.qpp.cms.gov
Advancing Care Information - 25% of MIPS

- Replaces Electronic Health Record (EHR) Meaningful Use
- Required minimum measures must comply with the following:
  - Security Risk Analysis. Must be HIPPA compliant or 0 pts
  - e-Prescribing
  - Provide Patient Access
  - Send Summary of Care
  - Request/Accept Summary of Care
  - Make sure it is certified EHR technology (CEHRT).

Cost

- No reporting Requirement for 2017
- Clinicians assessed on Medicare Claims data
- 0% of Final MIPS Score in 2017
- Feedback for 2017 data will be available by CMS
- Uses Measures seen in the Physician Value Based Modifier or the Quality and Resource Use Report (QRUR)
Bottom Line Impact of MIPS

• 2017 Performance in MIPS affects your Medicare payment 4% in 2019 → 9% in 2022
• All MIPS data are available for public reporting on Physician Compare
• Final Score available for public reporting
• Any questions for public reporting should be directed to PhysicianCompare@Westat.com

Adding up the MIPS Points

• Compare your top six Quality Measures against CMS benchmarks. 60 max Quality points → 60% of score
• Report Improvement activities and earn 10 points for medium weight activities and 20 points for high weight. 40 max Improvement Activity Points → 15% of score
• Report Advancing Care Info measures → 25% of score
### Transition Year Scoring - 2017

<table>
<thead>
<tr>
<th>Final Score</th>
<th>Payment Adjustment</th>
</tr>
</thead>
</table>
| ≥ 70 Points | • Positive adjustment  
|             | • Eligible for exceptional performance bonus – minimum of additional 0.5% |
| 4-69 points | • Positive adjustment  
|             | • Not eligible for exceptional performance bonus |
| 3 points    | • Neutral payment adjustment |
| 0 points    | • Negative payment adjustment of -4%  
|             | • 0 points = does not participate |

### MACRA is Offering Two Pathways to Clinicians

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- CMS promotes increased adoption of Advanced APMs

- Merit-Based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (APMs)
Advanced Alternative Payment Models

Advanced Alternative Payment Model

- Alternative to what?
- Alternative to “Fee for Service”

- What makes it “Advanced”
- Increased risk for the healthcare organization
  - use a certified electronic health record
  - payment based on quality measures that resemble MIPS
Timeline for Qualified Participants in Advanced Alternative Payment Models

Alternative Payment Model Examples

- CMS Innovation Center Models (other than the Health Care Innovation award)
- Medicare Shared Saving Program (any tracks)
- Medicare Health Care Quality Demonstration Program
- Demonstration Program required by Federal Law

www.qpp.cms.gov

https://qpp.cms.gov
Alternative Payment Models

Models of care which provide incentive payments

- High quality
- Cost-efficient value based care

Models are based on

- Specific clinical condition
- Care episode
- Population

Advanced Alternative Payment Models

- Advanced APMs are a subset of APMs
- Allow clinicians to earn higher incentive by taking risk
- Potential lump sum 5% incentive payment

https://qpp.cms.gov
Advanced APM Criteria Requirements

Certified EHR Technology

Payment based on MIPS comparable quality measures

Medical Home Model-expanded OR Bear more than a nominal financial risk

https://qpp.cms.gov

Shared Risk - Advanced APM’s

- Is a Medical Home Model expanded under CMS Innovation Center authority, OR Bear more than nominal amount of financial risk
- If actual expenditures exceed expected expenditures, 1 or more may apply.
  - Withhold payment for services to the APM Entity and/or the APM Entity’s eligible clinicians
  - Reduce payment rates to the APM Entity and/or the APM Entity’s eligible clinicians
  - Require direct payments by the APM Entity to CMS.
2017 Advanced APM Models

- 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


Qualifying Advanced APM Participant (QP)

- 25% of your Medicare Part B payments through the Advanced Alternative Payment Model, OR
- 20% of Medicare patients seen through the Advanced APM
- Report required Alternative Payment Model quality data
- If you have not joined an APM, you’re probably in MIPS
If you’re not in an Alternative Payment Model, check to see if you’re included in MIPS.

[qpp.cms.gov](http://qpp.cms.gov)
If in MIPS, pick 6+ measures

- COPD-Long Acting Bronchodilator
- COPD-Spirometry Evaluation
- Medication management for Persistent Asthma (age 5-64)
- Optimal Asthma Control (Outcome Measure)
- Sleep Apnea-Assessment of positive airway pressure (PAP) compliance
- Sleep Apnea- Assessment of Sleep Symptoms
- Sleep Apnea- PAP Therapy Prescribed
- Sleep Apnea –Severity Assessment (AHI or RDI) at Initial Diagnosis

If in Advanced Alternative Payment Model, Someone in Your Organization is Selecting for You

QPP 2018
Quality Payment Program: Final Policies

Transition Year 1 - 2017
- Excluded if you or your group has ≤ $30,000 in Part B allowed charges OR ≤ 100 Medicare Part B beneficiaries

YEAR 2 - 2018
- Excluded if you or your group has ≤ $90,000 in Part B allowed charges or ≤ 200 Part B beneficiaries
- Virtual Groups – 2 or more TINs (solo or group<10)
- Relief for clinicians impacted by hurricane and natural disasters

Virtual Groups
- Virtual groups election must occur prior to the beginning of the performance period and cannot be changed once the performance period starts
  - October 11 to December 31, 2017, for the 2018 MIPS
- Same submission mechanisms as groups.
- All clinicians within a TIN are part of the virtual group.
- Aggregate submission for each performance category
- Assessed and scored as a virtual group
- If TIN/NPIs is in both a virtual group and an APM, such TIN/NPI will receive a final score based on the virtual group performance and a final score based on performance in an APM. However, such TIN/NPI will receive a payment adjustment based on the APM score
MIPS Performance Categories for Y2

- Quality: 50
- Cost: 10
- Improvement Activities: 15
- Advancing Care Information: 25

100 Possible Final Score Points

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MIPS 2018

- Raising performance threshold to 15 points in year 2 – from 3 point threshold in Y1
- Allowing 2014 Edition a/o 2015 CEHRT
- 5 bonus points for complex patients – HCC (Hierarchical Condition Category)
- 5 bonus points for small practices
How many Advanced APMs in 2018

A. 8  
B. 11  
C. 15  
D. 38
### APM and Advanced APM 2018

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Timeline for Year 2

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Implementation

- Mostly a lot of work
- Educate stakeholders
- Take advantage of processes/reporting structures currently in place
- Form a team
  - Clinical leadership
  - Information technology staff and data analysts
  - Practice/project managers
  - Quality Improvement and programs staff
  - Billing staff
  - Finance staff
  - Senior leadership

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The only thing that is constant, is Change.

-Heraclitus

THANK YOU