Disclosures
- Nothing to Disclose

Goals and Objectives
- Know what MACRA did—and did not do—to change Medicare payment methodology
- Understand the basic nuts and bolts of the Merit-based Incentive Payment System (MIPS)
- Appreciate the distinction between an Alternative Payment Model and an Advanced Alternative Payment Model
- Recognize the need to succeed under MACRA’s Quality Payment Program (QPP)
- Know where to find additional information from the American Society of Anesthesiologists (ASA) and from the Centers for Medicare & Medicaid Services (CMS)
Known Knowns/Known Unknowns/Unknown Unknowns

- Known knowns: things we know we know.
- Known unknowns: things we know we don't know.
- Unknown unknowns: things we don't know we don't know.

(Donald Rumsfeld)

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The Known Knowns

There are known knowns. These are things we know we know. There are known unknowns. That is to say, there are things that we know we don't know. But there are also unknown unknowns. There are things we don't know we don't know.

(Donald Rumsfeld)

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Payment Equations

- (Base Units + Time Units) * Conversion Factor
- (RVU_work + RVU_pe + RVU_mp) * Conversion Factor

RVU: Relative Value Unit
pe: Practice Expense
mp: Malpractice Insurance
Conversion Factor: Pre-MACRA

Sustainable Growth Rate Formula (SGR)

- Spending target tied to Gross Domestic Product (GDP)
- Medicare Economic Index (MEI)
- Update Adjustment Factor (UAF)

Conversion Factor: Under MACRA

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- CF Updates set by statute
  - 2015-2019: 0.5%
  - 2020-2025: 0.0%
  - 2026 and on: MIPS 0.25%, APM 0.75%

Caution

CMS Estimate MEI for 2018: 2.4% (MedPAC, March 2017 Report to Congress)

Conversion Factor Calculations Still Include:

- RVU Budget Neutrality Adjustments
- Misvalued Code Target (through 2018)
Proposed 2018 Medicare Conversion Factors

TABLE 38: Calculation of the Proposed CY 2018 PFS Conversion Factor

<table>
<thead>
<tr>
<th>Description</th>
<th>Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upshift Factor</td>
<td>0.2%</td>
</tr>
<tr>
<td>CY 2018 PFS Budget Neutral Adjustments</td>
<td>0.0%</td>
</tr>
<tr>
<td>CY 2018 Target Relative Amount</td>
<td>0.1%</td>
</tr>
<tr>
<td>CY 2018 Conversion Factor</td>
<td>1.0%</td>
</tr>
<tr>
<td><strong>Total Conversion Factor</strong></td>
<td><strong>3.8%</strong></td>
</tr>
</tbody>
</table>

Source: CMS - Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements and Medicare Diabetes Prevention Program; Proposed Rule

You need to win in the QPP!

Path to Payment

Path?
MIPS Participants
(2017 Performance Period/2019 Adjustment)

- Above the Low Volume Threshold
  - ≤ $30,000 in Medicare allowed charges during determination period
    - 9/1/2015 – 8/31/2016
    - 9/1/2016 – 8/31/2017
  - ≤ 100 Medicare Part B patients
- Physician or specific type of non-physician practitioner
  - PA, NP, CNS or CRNA (or C-AA)
- Physician and eligible NPP not newly enrolled in Medicare program
- No significant participation in an Advanced APM

Check Eligibility Status - https://qpp.cms.gov
MIPS Exclusions by Reason and Specialty for MIPS Transition Year

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Clinicians (TIN/NPIs) Excluded by Reason</th>
<th>Total Exclusions</th>
<th>Total Inclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>1,180,032</td>
<td>85,484</td>
<td>481,546</td>
</tr>
<tr>
<td>Low Volume</td>
<td>12,764</td>
<td>1.1%</td>
<td>383,525</td>
</tr>
<tr>
<td>Newly Enrolled</td>
<td>2,159</td>
<td>4.3%</td>
<td>66,896</td>
</tr>
</tbody>
</table>

Anesthesiology

- Quality: 50,488, 4.3%
- Cost: 2,159, 4.3%
- Improvement Activities (IA): 171, 0.3%
- Advancing Care Information (ACI): 18,257, 36.2%

Nurse Anesthetist

- Quality: 59,974, 5.0%
- Cost: 3,364, 5.7%
- Improvement Activities (IA): 10, 0.0%
- Advancing Care Information (ACI): 31,703, 53.8%

MIPS Performance Categories

- Quality
- Cost
- Improvement Activities (IA)
- Advancing Care Information (ACI)

2017 Default Weights (%)

- Quality: 60%
- Cost: 15%
- Improvement Activities (IA): 25%
- Advancing Care Information (ACI): 0%

MIPS Classifications

- Non-Patient Facing
- Hospital-Based Clinicians

Eligible clinicians can check their Patient-Facing and Hospital-Based status at: https://qpp.cms.gov/participation-lookup/about
**Reweighting**

2017 Default Weights (%)

- **Quality**: 25
- **Cost**: 60
- **IA**: 15
- **ACI**: 15

2017 Weights if NPF, Hosp-based or NPP (%)

- **Quality**: 85
- **Cost**: 15
- **IA**: 15
- **ACI**: 15

**Quality - Scoring**

- Each measure earns 3 to 10 points
  - Transition Year Note:
    - Report 1 measure and earn minimum of 3 points even if 90 day period not met
    - Transition Threshold = 3

**Quality 2017/2019 General Reporting Requirements**

- Submitting via all mechanisms except CMS Web Interface
  - Report 6 measures including at least one outcome measure
    - Report one other high priority measure if no outcome measure is available
    - If fewer than 6 measures apply, report on each measure that is applicable
  - OR
  - Report one specialty-specific measure set
    - If set has >6 measures, report at least 6
    - Must report one outcome measure or another high priority measure if no outcome measure included in set
    - See 2017 Final Rule, Table E for Finalized MIPS Anesthesiology Measure set
  - Report on 50% of patients for 90 days

- Quality Scoring
  - Quality Score = (Points earned for 6 required measures) + (Any bonus points) / Maximum number of points
Cost
2017/2019 General Reporting Requirements

- Category has zero weight for 2017 performance/2019 payment year
  - CMS to provide feedback on performance
- Score based on CMS analysis of claims data
  - No separate submission/reporting requirements

Improvement Activities (IA)
2017/2019 General Reporting Requirements

- Attest to 4 medium-weighted activities or to 2 high-weighted activities
  - Table H in 2017 Final Rule: Improvement Activities Inventory
  - Over 90 activities
  - Check QPP Resource Library for details (MIPS Data Validation Criteria)
- Special Accommodations: Report 2 medium-weighted activities or 1 high-weighted activity
  - Small groups (< 15 clinicians)
  - Non-patient facing clinicians

IA Scoring

- Maximum score = 40 points:
  - High-weighted activities worth 20 points each
  - Medium-weighted activities worth 10 points each
  - Special Accommodations:
    - High-weighted activities worth 40 points each
    - Medium-weighted activities worth 20 points each

\[
\text{IA Score} = \frac{\text{Total number of points for reported activities}}{\text{Maximum number of points (40)}} \times 100
\]
Advancing Care Information (ACI)
2017/2019 General Reporting Requirements

- Must use certified EHR technology
- Report 5 required measures to score 50 points
- Report additional measures to earn more points up to maximum of 100 points for this component

- Special Accommodations: Exempt from ACI
  • Hospital-based Clinicians
  • Non-Patient Facing Clinicians
  • NPPs in MIPs
  • Other clinicians may apply for hardship exception

ACI Scoring

| Do not report required elements for base score | 0% |
| Report only required elements for base score | 50% |
| Report base requirements and additional elements | Up to 90% |
| Report for Bonus | Up to 15% |

ACI Score = Base Score + Performance Score + Bonus Score

Examples – 2019 Payment Adjustment Weights

[(Quality Score x Quality Weight) + (Cost Score x Cost Weight) + (IA Score x IA Weight) + (ACI Score x ACI Weight)]
Scores and Adjustments:
2017 Performance Period/2019 Payment Adjustment

<table>
<thead>
<tr>
<th>Score</th>
<th>Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Negative 4% adjustment</td>
</tr>
<tr>
<td>3</td>
<td>No adjustment</td>
</tr>
<tr>
<td>4-69</td>
<td>Positive adjustment</td>
</tr>
<tr>
<td>≥70</td>
<td>Positive adjustment and eligible for exceptional performance bonus</td>
</tr>
</tbody>
</table>

Payment Equations

(Base Units + Time Units) * CF
(RVU_{work} + RVU_{pe} + RVU_{mp}) * CF

CF: Conversion Factor
RVU: Relative Value Unit
pe: Practice Expense
mp: Malpractice Insurance

NEW Payment Equations

([(Base Units + Time Units) * CF] * MIPS Adjustment
([(RVU_{work} + RVU_{pe} + RVU_{mp}) * CF] * MIPS Adjustment

CF: Conversion Factor
RVU: Relative Value Unit
pe: Practice Expense
mp: Malpractice Insurance
The Centers for Medicare & Medicaid Services (CMS)

- Receives/reviews RUC recommendations
- Publishes its proposed values in the Proposed Rule for the upcoming year Medicare Physician Fee Schedule
- Typically published in early July
- Considers all comments received from any interested party
- Publishes decisions in Final Rule on Medicare Physician Fee Schedule
- Typically published in early November

Physician Fee Schedule is Chassis to QPP

Current System Impact on Future System

“The Department of Health and Human Services categorization of payment methods acknowledges that most value-based physician payment models being tested are built on top of the MPFS, as are the two value-based payment initiative that replaced the sustainable growth rate formula – the Merit-Based Incentive Payment System and Alternative Payment Models. If the foundation of Medicare’s fee schedule isn’t sound, these systems will be unstable.”

Targeted Percentage of Medicare FFS Payments Linked to Quality and Alternative Payment Models: 2016 and 2018

- **Category 1**: Fee for Service (FFS)
- **Category 2**: FFS w/ links to Quality and Value
- **Category 3**: APMs built from FFS
- **Category 4**: Population Based Payments

APMs and Advanced APMs

As defined by MACRA, APMs include:
- CMS Innovation Center model (under section 1115A, other than a Health Care Innovation Award)
- MSSP (Medicare Shared Savings Program)
- Demonstration under the Health Care Quality Demonstration Program
- Demonstration required by federal law

MACRA does NOT change how any particular APM functions or rewards value. Instead, it creates extra incentives for APM participation.

To be an Advanced APM, an APM must meet the following three criteria:
- Require participants to use certified electronic health record technology (CEHRT);
- Provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of the Merit-based Incentive Payment System (MIPS); and
- Either: (1) be a Medical Home Model expanded under CMS Innovation Center authority; or (2) require participating APM Entities to bear more than a nominal amount of financial risk for monetary losses.

Courtesy: Stan Stead, M.D.
### Quality Payment Program (QPP) Timeline: 2017 – 2020

<table>
<thead>
<tr>
<th>CY</th>
<th>MIPS Adjustment</th>
<th>MIPS Performance Period</th>
<th>MIPS Adjustment Range</th>
<th>Advanced APM Incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>+0.5%</td>
<td>Based on 2015 Performance</td>
<td>Year 1</td>
<td>+/- 0.5%</td>
</tr>
<tr>
<td>2018</td>
<td>+0.5%</td>
<td>Based on 2016 Performance</td>
<td>Year 2</td>
<td>+/- 0.5%</td>
</tr>
<tr>
<td>2019</td>
<td>+/−4.0%</td>
<td>Based on 2017 Performance</td>
<td>Year 3</td>
<td>+/- 5.0%</td>
</tr>
<tr>
<td>2020</td>
<td>0.0%</td>
<td>Based on 2018 Performance</td>
<td>Year 4</td>
<td>+/- 5.0%</td>
</tr>
</tbody>
</table>

CF Update: +0.25% MIPS / +0.75% APM

MIPS Adjustment Range: +/- 7.0% in 2021, +/- 9.0% 2022 and onward

Advanced APM Incentive: 5.0% through 2024

### The Known Unknowns

There are known knowns. These are things we know that we know. There are known unknowns. That is to say, there are things we know we don’t know. But there are also unknown unknowns. There are things we don’t know we don’t know.

(Donald Rumsfeld)

### Highlights: 2017 Final — 2018 Proposed

<table>
<thead>
<tr>
<th>Category Weighting</th>
<th>2017 Final</th>
<th>2018 Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality 60% / Cost 0% / ACI 25% / IA 15%</td>
<td>Report Quality, APM for minimum of 90 days</td>
<td>Report Quality for full year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reporting Requirements</th>
<th>2017 Final</th>
<th>2018 Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality, ACI and IA for minimum of 90 days</td>
<td>Report APM for minimum of 90 days</td>
<td></td>
</tr>
</tbody>
</table>

| Facility-Based Measurement Option | Not Available | Proposal to use facility measures as proxy for quality and costs for those who perform >75% of services in IP or Emergency room |

| Virtual Groups | Not Available | Proposal to allow groups with <10 ECs to form virtual groups to participate collectively in MIPS |

<table>
<thead>
<tr>
<th>Scores to Avoid Negative Adjustment, Earn Positive Adjustment</th>
<th>2017 Final</th>
<th>2018 Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scores</td>
<td>Adjustment</td>
<td>Score Adjustment</td>
</tr>
<tr>
<td>0</td>
<td>Negative adjustment</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>No adjustment</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>Positive adjustment</td>
<td>20.05</td>
</tr>
<tr>
<td>3</td>
<td>Positive adjustment and eligible for exceptional performance bonus</td>
<td>21.10</td>
</tr>
</tbody>
</table>
Proposed Patient Relationship and Category Codes

- Development mandated under MACRA
  - To attribute patients to one or more clinicians in certain elements of the QPP
- Optional
  - Payment does not depend on use of these modifiers

<table>
<thead>
<tr>
<th>Proposed Modifier</th>
<th>Patient Relationship Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>X1</td>
<td>Continuous/broad services</td>
</tr>
<tr>
<td>X2</td>
<td>Continuous/focused services</td>
</tr>
<tr>
<td>X3</td>
<td>Episodic/broad services</td>
</tr>
<tr>
<td>X4</td>
<td>Episodic/focused services</td>
</tr>
<tr>
<td>X5</td>
<td>Only as ordered by another clinician</td>
</tr>
</tbody>
</table>

Source: Table 26, CMS-1676-P

The Unknown Unknowns

There are known knowns. These are things we know that we know. There are known unknowns. That is to say, there are things that we know we don’t know. But there are also unknown unknowns. There are things we don’t know we don’t know.

(Donald Rumsfeld)

Physician – Focused Technical Advisory Committee (PTAC)

- Established under MACRA
  - Evaluates proposed payment models and makes recommendations to CMS
  - Expand beyond Medicare?
    - Medicaid, CHIP
- Since April 2017

<table>
<thead>
<tr>
<th>Number of Proposals Received/CMMI</th>
<th>31</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number Not Recommended</td>
<td>1</td>
</tr>
<tr>
<td>Number Withdrawn</td>
<td>1</td>
</tr>
<tr>
<td>Number Recommended for Limited Scale Testing</td>
<td>2</td>
</tr>
</tbody>
</table>

- CMS/CMMI Response
Federal Register 8/17/2017

- Proposes to:
  - Cancel Episode Payment Model (EPM) and Cardiac Rehab (CR) Incentive Payment Model
  - Revise Comprehensive Care for Joint Replacement (CJR) Model
    - Mandatory vs optional

Conclusions

- Conversion Factor updates will not allow you to keep pace with inflation and other rising costs – you need to do well in the Quality Payment Program (QPP)

- Most clinicians – including anesthesiologists – will start in the Quality Payment Program through MIPS and move toward APMs

- The rules and criteria for MIPS and APMs will change each year requiring physicians and their practices to stay informed and up-to-date

ASA Resources

- ASA Website
- ASA MACRA Reporting Workshops
- MIPS Reporting via NACOR
  - And more...
    - ASA MACRA Microsite
    - ASA MACRA Memo
MACRA's Physician-Focused Alternative Payment Model (PFPM) Options: A Multispecialty Perspective 60-Minute Refresher Course Lecture Session
10/23/17 2:20 – 3:20 PM

MACRA, MIPS and Impact on Daily Operations and Medical Decision Making in the Pain Clinics Problem-Based Learning Discussion Session
10/22/17 1:10 – 2:10 PM 10/24/17 2:10 – 3:10 PM

Confronting MACRA: Lessons Learned by Large Groups, Applicable to All Practices 60-Minute Panel Session
10/21/17 11:00 AM - 12:00 NOON

Reimbursements Under MACRA: Retooling Your Informatics System for Quality, Advancing Care Information, and Outcomes 120-Minute Panel
10/23/17 9:50 – 11:50 AM

AQI MACRA Reporting Seminar Seminar Session
10/22/17 1:10 – 5:10PM

...and More!

Thank You