MACRA – Quality Payment Program: A Primer for Ob/Gyns

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Timeline of American Health Care Financing

1912-1916
1912: TR Calls for Universal Coverage
1916: Federal Employee Compensation Act

1940s: FDR’s WWII wage & price controls prompt employers to sponsor health care insurance

1940s

1950s
1950s: Growth of employer sponsored insurance

1950s

1965
1965: LBJ’s Medicare and Medicaid - rolled out as a FFS payment, cost over-runs start immediately

1950s

1980-1990
1982: Hospital PPS-DRG (ICD-9) 1st Medicare cost control;
1992: Physician RBRVS (CPTs) 2nd Medicare cost control

1980-1990

1993-1997
1993: “Hilary care” defeated
1997: SCHIP, SGR Formula, Freeze on GME slots

1993-1997

2010-2017
2013: ACA-CMS VBP (IQR, HCAHPS, HRRP) to hospitals; MACRA VBP to MDs.
2017: Trump elected

2010-2017
Disclosures

• I have no conflicts of interest or relevant disclosures
Learning Objectives

• Understand historical origins of current U.S. public and private healthcare financing systems.
• Appreciate economic rationale for CMS value-based payment systems.
• Know impact of MACRA-QPP on your practice.
Organisation for Economic Co-operation and Development data
## National Population Health Outcomes and Risk Factors

<table>
<thead>
<tr>
<th>Country</th>
<th>Life exp. at birth, 2013&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Infant mortality, per 1,000 live births, 2013&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Percent of pop. age 65+ with two or more chronic conditions, 2014&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Obesity rate (BMI&gt;30), 2013&lt;sup&gt;a,c&lt;/sup&gt;</th>
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</thead>
<tbody>
<tr>
<td>Australia</td>
<td>82.2</td>
<td>3.6</td>
<td>54</td>
<td>28.3&lt;sup&gt;e&lt;/sup&gt;</td>
</tr>
<tr>
<td>Canada</td>
<td>81.5&lt;sup&gt;e&lt;/sup&gt;</td>
<td>4.8&lt;sup&gt;e&lt;/sup&gt;</td>
<td>56</td>
<td>25.8</td>
</tr>
<tr>
<td>Denmark</td>
<td>80.4</td>
<td>3.5</td>
<td>—</td>
<td>14.2</td>
</tr>
<tr>
<td>France</td>
<td>82.3</td>
<td>3.6</td>
<td>43</td>
<td>14.5&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td>Germany</td>
<td>80.9</td>
<td>3.3</td>
<td>49</td>
<td>23.6</td>
</tr>
<tr>
<td>Japan</td>
<td>83.4</td>
<td>2.1</td>
<td>—</td>
<td>3.7</td>
</tr>
<tr>
<td>Netherlands</td>
<td>81.4</td>
<td>3.8</td>
<td>46</td>
<td>11.8</td>
</tr>
<tr>
<td>New Zealand</td>
<td>81.4</td>
<td>5.2&lt;sup&gt;e&lt;/sup&gt;</td>
<td>37</td>
<td>30.6</td>
</tr>
<tr>
<td>Norway</td>
<td>81.8</td>
<td>2.4</td>
<td>43</td>
<td>10.0&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td>Sweden</td>
<td>82</td>
<td>2.7</td>
<td>42</td>
<td>11.7</td>
</tr>
<tr>
<td>Switzerland</td>
<td>82.9</td>
<td>3.9</td>
<td>44</td>
<td>10.3&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>81.1</td>
<td>3.8</td>
<td>33</td>
<td>24.9</td>
</tr>
<tr>
<td>United States</td>
<td>78.8</td>
<td>6.1&lt;sup&gt;e&lt;/sup&gt;</td>
<td>68</td>
<td>35.3&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td>OECD median</td>
<td>81.2</td>
<td>3.5</td>
<td>—</td>
<td>28.3</td>
</tr>
</tbody>
</table>

<sup>a</sup> Source: OECD Health Data 2015.<br><sup>b</sup> Includes: HTN, CVD, DM, COPD, mental health problems, Ca, arthritis. Source: Commonwealth Fund 2014.<br><sup>c</sup> DEN, FR, NETH, NOR, SWE, and SWIZ = self-reported data; all other countries based on measured OECD data.
Medicare spending is projected to increase gradually as a share of the federal budget and economy over the next 10 years.

### Net Medicare outlays as a share of the federal budget:

<table>
<thead>
<tr>
<th>Year</th>
<th>Net Medicare outlays in billions</th>
<th>Percent of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>$588</td>
<td>3.2</td>
</tr>
<tr>
<td>2017</td>
<td>$592</td>
<td>3.1</td>
</tr>
<tr>
<td>2018</td>
<td>$590</td>
<td>3.0</td>
</tr>
<tr>
<td>2019</td>
<td>$654</td>
<td>3.2</td>
</tr>
<tr>
<td>2020</td>
<td>$701</td>
<td>3.3</td>
</tr>
<tr>
<td>2021</td>
<td>$755</td>
<td>3.4</td>
</tr>
<tr>
<td>2022</td>
<td>$849</td>
<td>3.7</td>
</tr>
<tr>
<td>2023</td>
<td>$874</td>
<td>3.6</td>
</tr>
<tr>
<td>2024</td>
<td>$897</td>
<td>3.6</td>
</tr>
<tr>
<td>2025</td>
<td>$995</td>
<td>3.8</td>
</tr>
<tr>
<td>2026</td>
<td>$1,080</td>
<td>4.0</td>
</tr>
<tr>
<td>2027</td>
<td>$1,165</td>
<td>4.2</td>
</tr>
</tbody>
</table>

**NOTE:** All amounts are for federal fiscal years; amounts are in billions and consist of mandatory Medicare spending minus income from premiums and other offsetting receipts.

**SOURCE:** Congressional Budget Office, Budget and Economic Outlook: 2017 to 2027 (January 2017).
Employer Heath Care Costs: Premiums, Deductibles, Wages 2009 – 2016*

*Projected growth 2015-2016.

Deductibles in Private Plans Have Grown over the Past Decade

Percent adults ages 19–64 with private coverage*

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>No deductible</td>
<td>40</td>
<td>38</td>
<td>34</td>
<td>29</td>
<td>25</td>
<td>22</td>
</tr>
<tr>
<td>$1–$999</td>
<td>52</td>
<td>51</td>
<td>44</td>
<td>39</td>
<td>37</td>
<td>35</td>
</tr>
<tr>
<td>$1,000–$2,999</td>
<td>7</td>
<td>9</td>
<td>18</td>
<td>18</td>
<td>23</td>
<td>27</td>
</tr>
<tr>
<td>$3,000 or more</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>9</td>
<td>11</td>
<td>13</td>
</tr>
</tbody>
</table>

* Base is those who specified deductible.

Health care delivery is being restructured to align incentives across the spectrum to focus on value.
Defining Value-Based Care

• Historically, provider incentives driven by quantity of care ("fee-for-service"), rather than quality of care and its costs ("value")

• Given mounting financial pressure, stakeholders shifting from paying for volume to paying for value

• CMS had been leading the way to alternative payment models
Medicare Access and CHIP Reauthorization Act – now called the Quality Payment Program

• Passed in 2015 (92-8 in Senate; 392-37 in House)
• Ended flawed SGR- adjusts Medicare payments based on performance using a budget neutral format beginning in 2019
• Final rule released 11/17 (1600 pages)
• Combines and sunsets current CMS physician quality reporting programs (PQRS, VBPM, MU) end of this year.
• You will have two options:
  – Merit-based incentive payment system (MIPS)
  – Advanced Alternative Payment Models (A-APMs)
MACRA Final Rule (Quality Payment Program): Merit-based incentive payment system (MIPS)

• Increased number of excluded MD and practices:
  A. Low-volume threshold ≤ $90,000 in Medicare Part B charges or ≤ 200 Medicare patients
  B. Newly-enrolled clinicians
  C. Qualifying Participants (QP) in A-APM

• Quality and Cost measurements require full year of data while EHR and PI activities require ≥ 90 days

• Data thresholds increased from 50 to 60% of ALL pts

• Allows Ob/Gyn medical homes in A-APM
Merit-based incentive payment system (MIPS)

• Payments affected by results in 4 performance categories:
  1) Quality
  2) Cost – after 2019
  3) Advancing Care Information
  4) Clinical Practice Improvement Activities

• 0.5% annual base payment increase 2016-2019; then 0% through 2025 and 0.25% thereafter.

• Increasing portion of payment at risk (±4 to 9% from 2019 to 2022)
Merit-based incentive payment system (MIPS)

- Group Practices can report performance data via 3rd parties:
  1) Qualified Registries (QR);
  2) Qualified Clinical Data Registries (QCDRs);
  3) EHRs;
  4) CMS web interface
  5) CMS-approved survey vendor for Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPs

*Attestation for acceptable for EHR and improvement activities
Merit-based incentive payment system (MIPS)

• Individual Physicians can report performance data via 3rd parties by:
  1) Claims
  2) Qualified Registries (QR);
  3) Qualified Clinical Data Registries (QCDRs);
  4) EHRs;

*Attestation for acceptable for EHR and improvement activities
## MIPS Performance Categories

<table>
<thead>
<tr>
<th>Years</th>
<th>Quality Measures</th>
<th>Cost</th>
<th>Advancing Care Information</th>
<th>Improvement Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>60%</td>
<td>0%</td>
<td>25%</td>
<td>15%</td>
</tr>
<tr>
<td>2018</td>
<td>50%</td>
<td>10%</td>
<td>25%</td>
<td>15%</td>
</tr>
<tr>
<td>2019+</td>
<td>30%</td>
<td>30%</td>
<td>25%</td>
<td>15%</td>
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</tbody>
</table>
Quality Performance Category

Must choose 6 measures to report out of 27* for Ob/Gyn for one full year for:

1) 60% of Medicare Part B pts if reporting by claims
2) 60% of ALL pts if reporting by QR, QCDR, or EHR

*of 275 possible quality measures, most process not outcome related
Cost Performance Category

Based on:
1) Total per capita cost
2) Total spending per Medicare beneficiary
3) Calculated through one year of claims (no reporting requirements)
Advancing Care Information Category

For Ob/Gyns: 50 points base score elements including: e-Rx, patient access, security risk analysis, ability to send and receive summaries of care; 90 more performance score points for select measures plus bonus points for using registry. Must report > 90 consecutive days worth of data.
Clinical Performance Improvement Activities (CPIA) Category

• 110 activities to choose from
• Must achieve 40 points to get full score
  – Highly weighted activities worth 20 points
  – Medium weighted activities worth 10 points
• Must report 4 activities for > 90 consecutive days for 40 points; have 92 options (e.g., patient satisfaction survey, MOC part IV, team training).
MIPS Payment Adjustment:

- Clinicians assigned a score of 0 – 100 based on performance across all 4 categories.
- Score compared to entire U.S. CMS provider performance.
- A score above performance threshold results in bonus; score below results in penalty.
- Budget neutrality so scaling factor of up to 3X may be applied to bonuses (i.e., 37%).
## MACRA Quality Tiering Performance: Average Quality, Average Cost

<table>
<thead>
<tr>
<th>Group</th>
<th>Quality Composite Score</th>
<th>Cost Composite Score</th>
<th>Quality Tiering Performance</th>
<th>Estimated Payment Adjustment (2016)</th>
<th>Estimated $$ Impact (Based on $50M in Medicare Payments)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group A</td>
<td>0.84</td>
<td>-0.79</td>
<td>Average Quality Low Average Cost</td>
<td>0.00%</td>
<td>N/A</td>
</tr>
<tr>
<td>Group B</td>
<td>0.84</td>
<td>1.03</td>
<td>Average Quality High Average Cost</td>
<td>-1.00%</td>
<td>-$500,000</td>
</tr>
<tr>
<td>Group C*</td>
<td>-1.05</td>
<td>1.02</td>
<td>Low Quality Low Cost</td>
<td>-2.00%</td>
<td>-$1,000,000</td>
</tr>
</tbody>
</table>

**Diagram:**
- A: Group A
- B: Group B
- C: Group C*
MedPac: Problems with MIPS

- 40% of clinicians exempt
- Replicates flaws of prior value-based purchasing programs
- Burdensome, expensive and complex for MDs
- Much of reported information not meaningful
- MIPS will not succeed in helping beneficiaries choose high value clinicians.
MedPac: Alternative to MIPS

Voluntary value program:
1. Withhold is applied to all fee schedule payments and clinicians either:
   a) join voluntary “virtual” group and are measured as part of group or elect to be assessed by local market; performance assessed at group/local market level and withholds returned based on population-based outcome measures in categories of quality and value; or
   b) Join A-APM and have withhold returned; or
   c) Make no election and lose withhold
Advanced Alternative Payment Models (A-APMs)

To qualify must:

- Meet both Medicare and ALL payer payment and number cut-offs (e.g., 25% of Medicare payments and 20% of Medicare patients and 50% of total payment and 35% of total patients, cared through A-APM by 2019).

- A-APM will meet the financial risk requirement if CMS withholds payment, reduces rates, or requires the entity to make payments to CMS if its actual expenditures exceed expected expenditures.

- Require participants to use certified EHR technology (CEHRT).
Advanced Alternative Payment Models (AAPMs)

- Base payments on quality measures comparable to those used in the MIPS quality performance category.
- 5% annual bonus 2019-2024, annual baseline increases thereafter - plus keep what don’t spend.
- Base increases after 2026 of 0.75% vs. 0.25% for MIPS
Advanced Alternative Payment Models (AAPMs)

Examples include:

a. Comprehensive Primary Care Plus
b. Next Generation ACO
c. Shared Savings Programs Tracks 2 & 3
d. Critical Access Hospitals, Rural Health Clinics and FQHCs
e. Certain specialty 2-sided risk models (CRD, Ca)
### MACRA Summary

#### Anticipated annual baseline payment updates

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</thead>
<tbody>
<tr>
<td>2015</td>
<td>+0.5%</td>
<td>+0.5%</td>
<td>+0.5%</td>
<td>+0.5%</td>
<td>+0.5%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>2025</td>
<td>+0.5%</td>
<td>+0.5%</td>
<td>+0.5%</td>
<td>+0.5%</td>
<td>+0.5%</td>
<td>0%</td>
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<td>0%</td>
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</table>

#### Current law: PQRS, MU, VBPM

- Penalty up to -3.5%
- Penalty up to -6%
- Penalty up to -9%
- Penalty TBD

#### Merit-Based Incentive Payment System (MIPS)

- Adjustments made on sliding scale based on performance in prior time period TBD
- Baseline payment adjustment: (-/+) 4% to (-/+) 9%
- Maximum payment adjustment for high performers: +12% to +27%

#### Alternative Payment Models (APMs)

- 5% annual bonus – Paid in lump sum
- Participants are exempt from MIPS

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Legend:

- MU - Meaningful use
- PQRS - Physician Quality Reporting System
- VBPM - Value-Based Payment Modifier
- RVU - Relative Value Unit

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Notes:

- The projected 0.5% update, established by MACRA, was negated due to other legislative provisions. As a result, the 2016 conversion factor will be $35.82 instead of $35.00, which is a net reduction of 11 cents per Relative Value Unit (RVU).
- Lowest quartile performers automatically receive the maximum negative payment adjustment.
- Payment adjustment listed for 2023 through 2024 is an assumption based on currently available information.
- Exceptional performance criteria has not been defined.
Ob/Gyn Checklist

– Consider whether to report as an individual or a group TIN if you do not wish to participate.
– Check whether your EHR is certified by the Office of the National Coordinator for Health Information Technology: https://chpl.healthit.gov/#/search If certified, determine whether standard is for 2014 or 2015 – this will determine Advancing Care Information measures you can report.
– Check ACOG’s MACRA QPP webpages www.acog.org/macra.