Alphabet Soup: MACRA, QPP & MIPS

Stephanie Farnia, MPH
Tandem 2017

American Society for Blood and Marrow Transplantation
Agenda

ASBMT Health Policy Priorities for 2017

MACRA/QPP/OCM Overview

Implications for Transplant

Political Landscape and QPP

Upcoming Activities & Resources
Health Care Policy Activities

- **New core function of ASBMT**
  - Health care environment in the U.S. requires active participation

- **Value to members:**
  - Maintains specific focus on unique aspects of HCT
  - Education on emerging policy topics
  - Opportunities to engage in policy activities, bring value back to your programs
ASBMT Health Policy

- **Staff:**
  - Stephanie Farnia, Director
  - Dr. James Gajewski, Practice Policy Consultant

- **Collaboration with Partners:**
  - NMDP
  - CIBMTR
  - FACT
  - Participation in various ACP, AMA Specialty Society Activities

- **Goals for 2017:**
  - Understand various needs within ASBMT member groups
  - Identify members interested in representing HCT issues
2017 Health Policy Focus Areas

Patient Access – “Repeal and Replace”
- Access for HCT patients
- Proposed changes in payment systems

Preserve & Expand Research Funding
- Monitor Appropriations
- Assess unmet needs
- Communicate HCT use of current funds

Medicare
- Facility Payment
- Coverage of HCT
- Cell Acquisition

Provider Payment
- Codes for emerging cell therapy services
- New quality-based systems (MACRA/QPP)
- Valuation and status of E/M codes

US Immigration Policy
MACRA & QPP
## MACRA Definitions

**MACRA**: Medicare Access and Chip Reauthorization Act of 2015

**QPP**: Quality Payment Program

**Clinician**: Physician, Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist or Nurse Anesthetist

**MIPS**: Merit-based Incentive Payment System

**APM**: Advanced Alternative Payment Model

**OCM**: Oncology Care Model
“You say potato, I say...what???”

In short,

QPP = MACRA

MACRA = QPP + other initiatives
Purpose of the QPP

- “The Centers for Medicare & Medicaid Services (CMS) has a significant opportunity to collaborate with the clinical community to advance policy that pays for what works – both for clinicians and patients – to create a simpler, sustainable Medicare program” – QPP Executive Summary (emphasis added)
Objectives of the QPP
(paraphrased)

1. Improve beneficiary outcomes and engage patients
2. Enhance clinician experience through program design and tools
3. Increase availability and adoption of robust APMs
4. Promote program understanding and participation through customized education and outreach pathways
5. Improve data-sharing to provide accurate, timely and actionable feedback to providers and other stakeholders
6. Ensure operational excellence in program implementation and ongoing development
Goal: Address Projected Insolvency

Figure 8
Solvency Projections of the Medicare Part A Trust Fund, 2005-2016

<table>
<thead>
<tr>
<th>Report Year</th>
<th>Solvency Projection (Year)</th>
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<td>2015</td>
<td>2030</td>
</tr>
<tr>
<td>2016</td>
<td>2028</td>
</tr>
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</table>

Stating the Obvious:
QPP = Outpatient Focus

- For years, have been looking for the OPPS equivalent to DRGs
- Outpatient/Part B has been harder to tackle –
  - Diverse clinicians, specialties
  - Drastic variation in practice size
  - Partnerships with larger health systems or hospitals that may be involved in other payment models
Quality Payment Program: 2 Options

QPP

APM  MIPS
Financial Incentives

- $500 Million in play
- Needs to be budget neutral
MIPS
Merit-Based Incentive Payment System
Identified provider types that see more than 100 Medicare patients per year AND bill more than $30,000
- Based on Allowed Amounts billed under Part B
- Based on Tax Identification Number – could be group or individual

*QPP Helpline staff said that providers would receive a letter informing them of their qualification status*
- Sometime between Jan-May(?)

If anyone receives one of these letters, please let me know!
- Want to understand if CMS provides the data with which it made those determinations
- Based on October 1, 2015- September 31, 2016
MIPS Basics

What are the Performance Category Weights?
Weights assigned to each category based on a 1 to 100 point scale

Transition Year Weights

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

Note: These are defaults weights; the weights can be adjusted in certain circumstances
Quality

- Select **6 of 300** Quality Measures

- 1 must be a) Outcome Measure or b) High-Priority Measure (patient experience, safety, appropriate use, etc)

- List developed through PQRS process, adopted for use in MIPS

- Sample Hematology/Oncology measures available:
  - % of patients receiving chemotherapy in last 14 days of life
  - CLL: Baseline Flow Cytometry
  - MDS: Baseline Cytogenetic Testing of Bone Marrow

- For each measure, will receive score between 3-10 based on performance against benchmark.
Improvement Activities:
90 Activity Options in 9 Categories

- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary Engagement
- Patient Safety and Practice Assessment
- Participation in an APM*
- Achieving Health Equity
- Integrating Behavioral and Mental Health
- Emergency Preparedness and Response

Example: Engage patient and family in care plan development; document in EHR
Advancing Care Information

- aka Meaningful Use (aka Medicare EHR Incentive Program)
- Need to use Certified EHR Technology to report
  - Most vendors meet those standards
- Meet Advancing Care Information Measures
  - Electronic Prescribing
  - Sending summaries of care
  - Patient electronic access of medical record
Resource Use

- Not being evaluated on cost in 2017
- BUT – CMS is reviewing which care episodes to monitor, what costs to include, how to best set benchmarks
- Open for comment through April
  - ASBMT will be looking more closely into this and sending concerns
Where it gets messy...
Composite Score Calculation

Calculating the Final Score Under MIPS

\[
\text{Final Score} = (\text{Clinician Quality performance category score} \times \text{actual Quality performance category weight}) + (\text{Clinician Cost performance category score} \times \text{actual Cost performance category weight}) + (\text{Clinician Improvement Activities performance category score} \times \text{actual Improvement Activities performance category weight}) + (\text{Clinician Advancing Care Information performance category score} \times \text{actual Advancing Care Information performance category weight}) \times 100
\]
Minimum Options for 2017: Avoiding Financial Penalties

You Have Asked: “What is a minimum amount of data?”

1. Quality Measure

OR

1. Improvement Activity

OR

4 or 5 Required Advancing Care Information Measures
Four Options for Data Submission

- Submit Nothing
- Submit Full Year
- Submit between 90-365 Days
- Submit 90 Days

October 2\textsuperscript{nd} = 90-day mark
Pick your pace in MIPS: If you choose the MIPS track of the Quality Payment Program, you have three options.

- **Don’t Participate**: If you don’t participate in the Quality Payment Program, you receive a negative 4% payment adjustment.
- **Submit Something**:
  - Test: If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity), you can avoid a downward payment adjustment.
- **Submit a Partial Year**:
  - Partial: If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.
- **Submit a Full Year**:
  - Full: If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment.
Advanced Alternative Payment Models
APM ≠ Advanced APM

What is an Alternative Payment Model (APM)?

Alternative Payment Models (APMs) are new approaches to paying for medical care through Medicare that incentivize quality and value. The CMS Innovation Center develops new payment and service delivery models. Additionally, Congress has defined—both through the Affordable Care Act and other legislation—a number of demonstrations that CMS conducts.

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
Advanced APM Criterion

- Use of Certified EHR Technology
- Use of MIPS-Comparable Measures
  - Evidence-based, reliable and valid
- “Bears more than a nominal financial risk” (8% of total Part A and B revenue)
- 6 models currently qualify as Advanced APM; 1 relevant to HCT
  - Oncology Care Model (2-sided risk model only)
Advanced APM Benefits

(CMS’s preferred route)

What are the Benefits of Participating in an Advanced APM as a Qualifying APM Participant (QP)?

QPs:

- Are excluded from MIPS
- Receive a 5% lump sum bonus
- Receive a higher Physician Fee Schedule update starting in 2026
Oncology Care Model

- 6 month episode of care, triggered by outpatient chemotherapy infusion
- Fully burdened cost of care assessment against historical baseline episode, defined by diagnosis
  - Indications that have a likelihood of transplant were increased by a significant factor (1.9x)
  - Will be utilizing a registry starting in late 2017, potential for more specific adjustments based on disease sub-type, etc.
- Additional resources available to patients – 24-hour care line, electronic access to medical records, etc.
- Physician assignment of these episodes may be problematic
  - New CMS Specialty Designation will be helpful
Current OCM Locations

https://innovation.cms.gov/initiatives/oncology-care/
Payers Participating in the OCM

- Aetna
- Blue Cross Blue Shield of Michigan/Blue Care Network
- Blue Cross Blue Shield of New Mexico
- Blue Cross Blue Shield of Oklahoma
- Blue Cross Blue Shield of Texas
- BlueCross BlueShield of South Carolina
- Capital BlueCross, Inc.
- Cigna Life & Health Insurance Company
- EmblemHealth
- Health Alliance Plan
- Highmark, Inc.
- Priority Health
- SummaCare
- The University of Arizona Health Plans
- UPMC Health Plan
- VIVA Health, Inc.
QPP/OCM and Cellular Therapies

- How do these systems handle new technologies?
  - OCM is supposed to have a mechanism of excluding certain new high-cost drugs/therapies from the calculations
  - Unknown if the private payers will allow the same exclusions
  - QPP does not mention new therapy adjustments

- New products coming to market will need to plan for these kinds of calculations/impacts to providers, as well as RVUs
Implications for HCT
Implications for HCT

- The Part B care being included is not the bulk of HCT care
- Center-specific decisions and data collection – HCT specific or uniform care measures
- Need community-level development of MIPS measures
- On-going resources focused on monitoring and reacting to proposed changes
Part B HCT Care: Infusions & Chemotherapy

- For most transplant MDs, the care being assessed will be:
  - Consultations and Follow-up Visits (E/M codes)
  - Apheresis supervision
  - Bone marrow biopsies
  - Infusions
  - Care Management/Transition Care Management Codes

- If the transplant physicians/physician practice owns the infusion center, beneficiary chemotherapy sessions will be included
Estimated Burden for Quality Reporting in MACRA Final Rule

Estimated time and cost burden for quality-performance category, by type of submission

- **Claims submission mechanism**
  - Minimum: 8.2 hours
  - Maximum: 18.8 hours
  - Final rule: 7.2 hours
  - Proposed rule: 17.8 hours
  - Minimum cost: $406
  - Maximum cost: $1,294

- **Qualified clinical data registry**
  - Minimum: 10.1 hours
  - Maximum: 11 hours

- **Electronic health record**
  - Minimum: 11 hours
  - Maximum: 12 hours
  - Minimum cost: $647
  - Maximum cost: $724

- **Group submission via CMS web interface**
  - Minimum: 0.22 hours (13 minutes)
  - Maximum: 0.23 hours (14 minutes)
  - Minimum cost: $1
  - Maximum cost: $19

*Burden estimate applies to those MIPS-eligible clinicians submitting data through these mechanisms either as individuals or as a group.
Sources: CMS final rule and proposed rule for implementing Quality Payment Program under Medicare Access and CHIP Reauthorization Act of 2015

By Janie Boschma, POLITICO Pro DataPoint
Providers Spend $40,000 Per Physician on Quality Reporting

Perceptions physician practices had on external quality measures in 2014, by specialty

- Measures were "moderate" or "very representative" of the quality of care
- Groups' effort in dealing with measures was "more" or "much more" than three years earlier.
- Multiple similar measures caused "significant" or "extreme" burden
- Scores were used "frequently" or "very frequently" to improve quality

Measure Development Process

- Likely to pursue National Quality Forum process
  - Lengthy, rigorous
  - Will almost definitely miss timeframe for 2019 adoption

- How do we make them things we can measure easily?

- How do we not burden smaller programs further?
  - May have limited IT capacity, etc

- If we build it, will programs use it?
  - Program vs. Hospital-wide measure election

- Replacement by specialty-specific AAPM?
Politics & the QPP
Will it stay?

- The short answer = we think so.
- Bi-partisan support, previous method for handling physician payment development was broken.
- Push towards quality-based payment will stay, even if this program shape-shifts.
- BUT – a lot could happen between now and 2019 payments.
Can CMS Do It?

- Expect 600,000 clinicians to be eligible to submit data
- MASSIVE data issue for CMS – collection, processing, decision-making, communication back to hospitals
  - Currently struggle with HCAPS survey upload volume
- Need to navigate this through multiple rule-making periods
- Provider shifts – clinician-level, hospital/health system level
- Groups will be seeking additional measures and AAPMS
- **Much harder than IPPS – QPP is delayed vs. real-time payment**
The Price Effect: HHS Leadership Changes

Price’s Perspective:

- Increase MD Autonomy
- Decrease regulation and reporting
- QPP detailed requirements and burden on providers make it a target for change
- OCM/CMMI most vulnerable
Perspectives on QPP

System Consolidation?
- Small numbers on MD side could equal substantial payments/penalties
- Technology needed to do this reporting usually only supported by larger systems
- $100M made available to support small group transition
Health Affairs – QPP is just next attempt; many more to come

The Changing Payment Landscape Of Current CMS Payment Models Foreshadows Future Plans
David Muhlestein, Natalie Burton, and Lia Winfield
February 3, 2017
MACRA Implementation Drives New Groups to Lobby Congress

Top 20 groups lobbying MACRA implementation, total spending by quarter

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<thead>
<tr>
<th>Entity</th>
<th>Q1 2016</th>
<th>Q2 2016</th>
<th>Total</th>
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<tr>
<td>American Hospital Assoc.</td>
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<tr>
<td>Blue Cross Blue Shield</td>
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<td>America’s Health Insurance Plans</td>
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<td>Health Care Service Corp.</td>
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<tr>
<td>American Assoc. of Orthopaedic Surgeons</td>
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<td>American Physical Therapy Assoc.</td>
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<td>American College of Surgeons</td>
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Note: Entity totals do not include subsidiary lobbying. Dollar amounts rounded.

Source: U.S. Senate lobbying disclosures

By Janie Boschma and David Pittman, POLITICO Pro
Groups Ask CMS to Reduce MIPS Quality Reporting Burden

Estimated time and cost burden for quality performance category, by type of submission

<table>
<thead>
<tr>
<th>Submission Mechanism</th>
<th>Annual Hours Per Physician</th>
<th>Annual Cost Per Physician</th>
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<tbody>
<tr>
<td>Claims submission mechanism</td>
<td>Minimum: 7.2 hours</td>
<td>Minimum: $406.13</td>
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<tr>
<td></td>
<td>Median: 8.6</td>
<td>Median: $520.32</td>
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<td></td>
<td>Maximum: 17.8</td>
<td>Maximum: $1,294.43</td>
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<tr>
<td>Qualified Clinical Data Registry*</td>
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<td>Electronic Health Record*</td>
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<td>$723.50</td>
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<tr>
<td>Group submission via CMS web interface</td>
<td>Average: 0.23 hours (14 minutes)</td>
<td>$18.27</td>
</tr>
</tbody>
</table>

* Burden estimate applies to those MIPS eligible clinicians submitting data through these mechanisms either as individuals or as a group.

Sources: CMS proposed rule for Medicare Access and CHIP Reauthorization Act of 2015; Medicare Payment Advisory Commission’s June 2016 report to Congress

By Janie Boschma, POLITICO DataPoint
PQRS = Warning of Future Issues

- Recent AMA meeting of subspecialties in Chicago
  - 2017 is the payment/penalty year for 2015 data

- Numerous practices set to receive ‘undue’ bonuses or pay substantial penalties based on PQRS assessments
  - Specialties with small/independent practices hearing many complaints with the way assessment of care, resource use was done
  - Do not feel adequate adjustment is done for location, staff costs

- Petitioning CMS to zero out the penalties because of MIPS implementation

- Substantial burden associated with Certified Quality Data Registry activation and maintenance
Delayed Timeline Creates Opportunity for Change

- 2017 data will be evaluated in 2018
- 2018 determinations will be paid in 2019
- For societies that were participating in the risk-sharing versions of PQRS, they are requesting to ‘zero out’ the penalty
  - Citing issues with geographic benchmarks and risk adjustment
- Will the delayed payment schedule create a window for program modification between early results and payment?
Activities & Resources
QPP Help Center

Need Help
The Quality Payment Program Service Center is available to help.
1-866-288-8292
TTY: 1-877-715-6222
Available Monday – Friday, 8:00AM – 8:00PM Eastern Time

Questions
Send us your questions about the Quality Payment Program.
QPP@cms.hhs.gov

Subscribe to Updates
Receive the latest Quality Payment Program updates.

Main page = www.QPP.CMS.GOV
QPP To-Do List

Next 30 days – Identification:
- Are you in an Advanced APM or will you be in MIPS?
- Are your clinicians considered Qualified?
- Who is making the decisions in your organization for Quality Measures?

Following 90 days – Implementation:
- If possible, put forward suggestions on Quality Measures used
- Begin physician education process
- Begin data collection/submission process (if want potential +)
HCT Community Activities

- **CIBMTR:** Evaluating feasibility/usefulness of SCTOD as a QPP-qualified registry

- **ASBMT:**
  - Committee on Quality Outcomes to evaluate development of HCT specific quality measures (use of NQF framework?)
  - Education of membership
  - Evaluate potential for HCT-specific APM
  - Advocacy with CMS on aspects in development

- **All of you:** Share issues/concerns that come up
  - Allows ASBMT to investigate, learn share further
  - AMA convenes subspecialty groups to identify common problems
Thank you!

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