A Practical Guide to Navigating MACRA

Prepared for Annual Community on Oncology Conference

Avalere Health | An Inovalon Company
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Presentation Overview

1 | The Shift to Value-Based Payment

2 | MACRA and the Quality Payment Program (QPP)

3 | Merit-Based Incentive Payment System (MIPS)

4 | Advanced Alternative Payment Model (AAPM)

5 | The Oncology Care Model (OCM)
Despite Some Elimination of Mandatory Programs, the Shift Toward Value-Based Payment Will Continue

Old Paradigm

Paying for Volume
- Fee-for-service payments
- Perverse incentive to increase healthcare utilization

Evolving Paradigm

Paying for Performance
- Pay for reporting on quality measures
- Provide incentives for high quality outcomes

Paying for Higher Value
- Shared savings or capitated payments
- Incents providers to coordinate care across continuum
Continued Payment Reform Increasingly Shifts Risk to Providers & Drives Value-based, High Quality Care

### THE EVOLUTION OF VALUE-BASED CARE

<table>
<thead>
<tr>
<th>PAST</th>
<th>PRESENT</th>
<th>FUTURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS</td>
<td>VBP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Partial Capitation</td>
<td>Full Capitation</td>
</tr>
<tr>
<td></td>
<td>Episodic Bundles</td>
<td></td>
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<tr>
<td></td>
<td>Shared Savings</td>
<td></td>
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<tr>
<td></td>
<td>VBP</td>
<td></td>
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</tbody>
</table>

**Transfer of Risk and Increased Value Imperative**

*Quality Measures Assess Care Value in New Payment Models*

FFS = Fee for Services, VBP = Value Based Purchasing

The Medicare Access & CHIP Reauthorization Act (MACRA) & the Quality Payment Program (QPP)
MACRA Established the Quality Payment Program (QPP), Further Encouraging the Shift to Value-Based Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) – enacted on April 16, 2015 and finalized on October 14, 2016 – establishes a comprehensive framework for providers to move to a value-based payment system.

Specifically, MACRA:

1. Permanently repealed the Sustainable Growth Rate (SGR) formula
2. Stabilized Medicare payments to physicians with a 0.5% payment update in each of the four years before the start of the MIPS
3. Established the QPP, a Medicare physician payment system with consolidated quality and value programs
4. Encouraged providers to participate in Advanced APMs

MACRA: Medicare Access and CHIP Reauthorization Act; QPP: Quality Payment Program; MIPS: Merit-Based Incentive Payment System; APM: Alternative Payment Model
### MACRA Provides Steady Annual Payment Updates & a Consolidated Quality & Value Program

#### OPTION 1 – PARTICIPATION IN THE MIPS

<table>
<thead>
<tr>
<th>Physician Fee Schedule Updates</th>
<th>0.25%</th>
<th>0.0%</th>
<th>0.25%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MIPS Payment Adjustments</strong></td>
<td>+/-4%</td>
<td>+/-5%</td>
<td>+/-7%</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>+/-9%</td>
</tr>
</tbody>
</table>

#### OPTION 2 – PARTICIPATION IN AN ADVANCED APM

<table>
<thead>
<tr>
<th>Physician Fee Schedule Updates</th>
<th>0.25%</th>
<th>0.0%</th>
<th>0.75%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A-APM Bonus</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5% lump sum bonus payment annually</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026

#### Reporting and performance in 2017 will impact 2019 payment

Source: H.R. 2 — 114th Congress: Medicare Access and CHIP Reauthorization Act of 2015 & BBA
Although a Majority of Providers Will Participate in MIPS, Participation in Advanced APMs Will Grow Over Time

**MIPS:** Approximately 592,000 to 642,000 clinicians were required to participate in MIPS in the 2017 transition year

**Advanced APM:** Approximately 70,000 to 120,000 clinicians will become QPs in 2017

**CMS predicts 75 percent of clinicians will participate in the MIPS and 25 percent (125,000 to 250,000) as part of an Advanced APM in 2018**

APM: Alternative Payment Model; MIPS: Merit-based Incentive Payment System; QPP: Quality Payment Program

QP: Qualifying Participant; CMS: Centers for Medicare & Medicaid Services

Oncologists Have Options Under QPP

### QPP Tracks for Oncologists

<table>
<thead>
<tr>
<th>MIPS Only</th>
<th>MIPS &amp; OCM</th>
<th>AAPM</th>
<th>Other (2-sided risk)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS Payments</td>
<td>FFS Payments</td>
<td>FFS Payments</td>
<td>FFS Payments</td>
</tr>
<tr>
<td>MIPS Payment Adjustments</td>
<td>MIPS Payment Adjustments</td>
<td>AAPM 5% Bonus Payment (2019-2024)</td>
<td>AAPM 5% Bonus Payment (2019-2024)</td>
</tr>
<tr>
<td>OCM Payments</td>
<td>OCM Payments/Losses</td>
<td>APM Payments/Losses</td>
<td></td>
</tr>
</tbody>
</table>

**OCM participants can switch back-and-forth between 1-sided and 2-sided risk**

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*Only APMS with 2-sided risk qualify as Advanced APMS (AAPMs)*

QPP: Quality Payment Program; EHR: Electronic health record; PQRS: Physician Quality Reporting System; VM: Value-based payment modifier; MIPS: Merit-Based Incentive Payment System

MIPS Performance Weights Emphasize Quality

There is a two year lag between reporting and when clinicians receive their incentive payment (i.e. Reporting in 2017 impacts 2019 payment)

<table>
<thead>
<tr>
<th>Year</th>
<th>Cost</th>
<th>Quality</th>
<th>Advancing Care Information</th>
<th>Improvement Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017 Weighting</td>
<td>15%</td>
<td>25%</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td>2018 Weighting</td>
<td>10%</td>
<td>25%</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td>2019 Weighting</td>
<td>10%</td>
<td>25%</td>
<td>15%</td>
<td>50%</td>
</tr>
</tbody>
</table>

MIPS: Merit-based Incentive Payment System; EP: Eligible Professional; BBA: Bipartisan Budget Act
Source: Medicare Program; CY 2018 Updates to the Quality Payment Program. Proposed Rule. Available [here](#)
Participating Clinicians Have Several Choices for Reporting Quality Measures Under MIPS

Provider selection of measures or measure sets on which to report will likely be driven largely by practice service mix.

<table>
<thead>
<tr>
<th>Select from MIPS Measure List or QCDRs</th>
<th>Select Specialty or Sub-Specialty set</th>
<th>Report as a Group</th>
<th>Report as a MIPS APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report on 6 quality measures (including at least one outcome measure, if available*) from the all MIPS measures list.</td>
<td>Report on 1 specialty-specific or subspecialty-specific*** measure set</td>
<td>Groups reporting through the CMS Web Interface report on a set of 14 Medicare Share Savings Program measures</td>
<td>MIPS APMs report on APM measure sets; certain APMs who do not meet the criteria to qualify as an AAPM or have insufficient payment and patient volume may report under MIPS (MIPS APMs)+</td>
</tr>
</tbody>
</table>

*Where no outcome measure is available, a clinician must report on a high priority measure.

**CMS defines applicable measures as those “relative to a particular MIPS clinician’s services or care rendered.” CMS will determine applicability based on claims data.

***Where sub-specialty measure sets are available, CMS recommends reporting on that set.

+APMs who do not meet the payment and patient volume thresholds will have the option to report under MIPS.
45 Oncology Measures Were Finalized Under the MIPS Quality Performance Category

For measurement year 2017, 45 measures were finalized for oncology, including 11 measures that are new for MIPS (not previously in PQRS). An oncology specialty set has also been identified.

1. A number of measures address general oncology topics, including:
   - End-of-life and palliative care
   - Pain management – topped out

2. Additional measures address screening and care management for specific cancer types, including:
   - Breast Cancer – most if not all topped out
   - Cervical Cancer
   - Colorectal Cancer – some topped out
   - Hematologic Cancer – some topped out
   - Lung Cancer – some topped out
   - Melanoma – all topped out
   - Prostate Cancer – some topped out

Virtually all the current oncology measures in the MIPS program are topped out and most of them are only available via claims. This leaves opportunities to create new measures and examining existing measures for other appropriate formats.

MIPS: Merit-Based Incentive Payment System; PQRS: Physician Quality Reporting System
CMS defines a topped out measure as a measure where the performance is consistently high across providers that meaningful distinctions and improvement in performance can no longer be made.
CMS Plans to Add “Improvement Scoring” to the Cost Performance Methodology in Performance Year 2018

The improvement score rewards clinicians for improving their cost categories scores over time.

Improvement Score Formula

\[
\text{Cost Improvement Score} = \frac{\text{Number of cost measures with significant improvement in performance}}{-\text{Number of cost measures with significant declines in performance}} \times \frac{\text{Total number of cost measures}}{}
\]

Final Cost Score Formula

\[
\text{Cost Performance Category Percent Score} = \frac{\text{Cost Achievement Points}}{-\text{Available Cost Achievement Points}} + \text{Cost Improvement Score}
\]

Clinicians can earn bonus points on their cost category score if they demonstrate cost improvement between performance years.
Advanced Alternative Payment Model (AAPM)
AAPMs Must Meet 3 Criteria

- Require participants to use Certified Health IT
- Pay providers based on quality measures comparable to MIPS
- APM entities must bear more than nominal financial risk (includes financial mechanisms and thresholds)

AAPM Clinicians Can Earn Payment Incentives

<table>
<thead>
<tr>
<th>Incentive</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part B Bonus Payment (2019—2024)</td>
<td>5%</td>
</tr>
<tr>
<td>CF Update* (2026+)</td>
<td>0.75%</td>
</tr>
</tbody>
</table>

*All other clinicians will receive a 0.25% update to the fee-for-service CF.

AAPM: Advanced Alternative Payment Model; CF: Conversion Factor; MIPS: Merit-based Incentive Payment System; IT: Information Technology
The Number of APMs That Qualify as AAPMs Continues to Grow

CMS will explore testing and introducing new AAPMs to incentivize greater participation, particularly among specialists and rural providers

<table>
<thead>
<tr>
<th>Anticipated APMs</th>
<th>2017</th>
<th>2018</th>
<th>2019+</th>
<th>Other Payer AAPMs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSSP ACO Track 2</td>
<td></td>
<td>MSSP ACO Track 3</td>
<td>MSSP ACO Track 1+</td>
<td>Voluntary Bundled Payment Model</td>
</tr>
<tr>
<td>Comprehensive ESRD Care Model</td>
<td></td>
<td>Comprehensive Primary Care Plus Model</td>
<td>Comprehensive Care for Joint Replacement (CJR) (CEHRT Track)</td>
<td>Vermont Medicare ACO Initiative</td>
</tr>
<tr>
<td>(two-sided risk option)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Next Generation ACO</td>
<td></td>
<td>Oncology Care Model (two-sided risk option)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Medicare Advantage
2. Medicaid
3. Commercial

MSSP: Medicare Shared Savings Program; ACO: Accountable Care Organization; ESRD: End-Stage Renal Disease AAPM: Advanced Alternative Payment Model
PTAC Will Make New APM Recommendations

PTAC is charged with reviewing and commenting on PFPM proposals submitted by stakeholders and determining whether the proposals meet certain criteria.

The criteria that PTAC will use to make recommendations include:

- Scope of the Proposed Model
- Promoting Quality and Cost
- Value over Volume
- Flexibility for Practitioners
- Payment Methodology
- Evaluation Goals
- Integration and Care Coordination
- Patient Choice
- Patient Safety
- Health Technology and Information

Only APMS with 2-sided risk qualify as Advanced APMS (AAPMs)

APM: Alternative Payment Model; QPP: Quality Payment Program; PTAC: Physician-Focused Payment Model Technical Advisory Committee; PFPM: Physician-Focused Payment Model; CMMI: Center for Medicare & Medicaid Innovation

Oncology Care Model (OCM)
What is CMMI’s Oncology Care Model, & What Are Its Goals Over the Coming Years?

CMMI’s OCM is an innovative, multi-payer model focused on providing higher quality, more coordinated oncology care

OCM Goals:

1. To align financial incentives to improve the quality of cancer care while reducing costs associated with patients receiving chemotherapy
2. To further partner with oncologists, other related providers and commercial health insurance plans
3. To continue moving toward paying providers based on the quality, rather than the quantity of care they give patients
4. To build upon experience and lessons learned from other bundled payment structures

1 CMMI = Center for Medicare & Medicaid Innovation
2 OCM = Oncology Care Model
The OCM Does Not Require Practices to Accept Risk

1-SIDED RISK
Available for all performance years

<table>
<thead>
<tr>
<th>Upside</th>
<th>2-SIDED RISK</th>
</tr>
</thead>
</table>

| 1-SIDED RISK | 2-SIDED RISK |

<table>
<thead>
<tr>
<th>Upside</th>
<th>Participants can achieve performance-based payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Downside</td>
<td>Participants have to pay back any Medicare expenditures over the target price</td>
</tr>
</tbody>
</table>

Practices opting into the two-sided risk get a lower discount percentage resulting in higher target prices and the ability to earn higher PBPs

OCM = Oncology Care Model; PBP = Performance-Based Payment

Discount percentage included in the target price

4% vs 2.75%
Under the OCM, Practices Must Meet Certain Criteria

<table>
<thead>
<tr>
<th>24/7 Patient Access</th>
<th>Patient Navigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide 24/7 patient access to the appropriate clinician with real-time access to the practice’s medical records</td>
<td>• Provide core functions of patient navigation to all patients in the model</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Electronic Health Records</th>
<th>Continuous Quality Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Use certified-EHRs (participants must attest to meaningful use of ONC-certified technology that will support Stage 2 meaningful use)</td>
<td>• Utilization of practice data and Medicare claims data to improve performance and achieve goals of OCM. Practices will also have to report on several quality measures required by OCM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Institute Of Medicine Care Plan</th>
<th>Clinical Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Documentation of care plans that include the components of the IOM Care Management Plan</td>
<td>• Use of nationally recognized clinical guidelines (National Comprehensive Cancer Network or American Society of Clinical Oncology), and must report when they deviate from guidelines</td>
</tr>
</tbody>
</table>

EHR = Electronic Health Record
IOM = Institute of Medicine
OCM = Oncology Care Model
The OCM Provides an Episode-Based Payment Split into Two Payment Types

<table>
<thead>
<tr>
<th>Per-Beneficiary-Per-Month (PBPM) Payments</th>
<th>Performance-Based Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supports delivery of required enhanced services</td>
<td>Incentive to reduce costs and improve outcomes</td>
</tr>
<tr>
<td>• $160 per OCM beneficiary, paid per month for each 6-month episode</td>
<td>• For higher-volume cancer types, practices are eligible to receive up to the difference between the target price and total spending during the episode</td>
</tr>
<tr>
<td>o Paid during the episode</td>
<td>o Retrospectively paid after the episode ends</td>
</tr>
<tr>
<td>o Billed by practices through a new HCPCS G-Code</td>
<td>o Total spending on the episode includes the PBPM</td>
</tr>
<tr>
<td>o Practices may not bill the PBPM and chronic care management services or transitional care management services during the same month for the same beneficiary</td>
<td>o May be scaled down by performance on quality measures through the quality multiplier</td>
</tr>
<tr>
<td></td>
<td>o Target prices cannot be calculated for lower-volume cancers, so they will not be eligible for performance-based payments</td>
</tr>
</tbody>
</table>

1. OCM episodes initiate when a patient receives chemotherapy and extends 6 months
2. Providers who treat OCM beneficiaries continue to receive Medicare FFS Payments during the OCM episode

1 FFS = Fee-for-Service
2 HCPCS = Healthcare Common Procedure Coding System
3 OCM = Oncology Care Model; PBPM = Per Beneficiary Per Month
Quality Measures Affect Performance-Based Payments

The performance-based payment (PBP) may be scaled down by the performance multiplier.

<table>
<thead>
<tr>
<th>Quality Measures Affect Performance-Based Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximum available performance-based payment</strong></td>
</tr>
<tr>
<td>Eligible to receive up to the full difference between the target price and Medicare’s actual expenditures for the episode</td>
</tr>
<tr>
<td><strong>Determine performance on quality measures</strong></td>
</tr>
<tr>
<td>Participant performance will be transformed into weighted scores to calculate a practice-specific performance multiplier</td>
</tr>
<tr>
<td><strong>Apply performance multiplier and other adjustments</strong></td>
</tr>
<tr>
<td>Performance multiplier may reduce, but not increase, the performance-based payment</td>
</tr>
</tbody>
</table>

**EXAMPLE CALCULATION**

- **Target price**: $100
- **Actual spend**: $90
- **Max PBP**: $10

Performance Multiplier: .95

<table>
<thead>
<tr>
<th>Performance Multiplier &amp; other adjustments x .95</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Max PBP</strong>: $10</td>
</tr>
<tr>
<td><strong>Performance Multiplier</strong>: .95</td>
</tr>
<tr>
<td><strong>PBP</strong>: $9.5</td>
</tr>
</tbody>
</table>

OCM = Oncology Care Model; PBP = Performance-Based Payment

*Calculation is for example purposes only*

Source: CMMI, “Oncology Care Model Request for Applications, February 2015 (Updated June 3, 2015)”

CMMI Will Use Retrospective Reconciliation to Calculate Performance-Based Payments

CMMI = Center for Medicare and Medicaid Innovation
MEOS = Monthly Enhanced Oncology Services
TCOC = Total cost of care
CMS Introduces New Risk-Adjustment Approach for OCM

Risk adjustment is applied using the OCM prediction model and practice adjustment factors for experience and use of novel therapies.

**Prediction Model:**
- Calibrated using the national set of baseline period episodes: July 2012 – June 2015
- Estimated by regressing baseline episode costs on a list of covariates that influence episode cost, including: cancer type, age, sex, Medicaid status, comorbidities, and prior cancer treatment
- Used to calculate a ‘predicted’ baseline for each episode

**Experience Adjuster**
- Controls for unmeasured selection at the practice level: 50 percent of the ratio of practice’s actual baseline expenditures to its predicted baseline expenditures

**Adjustment for Novel Therapies**
- Controls for use of novel therapies: 80 percent of the ratio of practice’s use of specified novel therapies to their use by non-OCM participating practices, if ratio is greater than 1

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Practices opting into the two-sided risk get a lower discount percentage resulting in higher target prices and the ability to earn higher PBP.

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1 OCM = Oncology Care Model
2 CMMI = Center for Medicare & Medicaid Innovation
Improving AAPM Options for Oncology Care

CMMI demonstrations are experimental. Both CMS and oncologists will want changes. It is important to discover what works.

- CMS made substantial changes to pioneer aco program, and created next generation ACO program before pioneer demo ended
- CMS has made some changes to OCM already
## What QPP Means for Oncologists

1. Majority of Eligible Clinicians will participate in the MIPS track due to the stringent criteria for participating under AAPMs

2. Opportunity to participate in an AAPM does not exist for all Eligible Clinicians, making the MIPS track mandatory for those who do not qualify for the AAPM track

3. Oncologists are in MIPS unless they are in 2-sided risk OCM or other qualifying AAPM

4. BBA slows implementation of MIPS, reducing both positive and negative payment adjustments, and thereby shifts relative financial rewards more strongly toward AAPMs.

QPP: Quality Payment Program; MIPS: Merit-Based Incentive Payment System; AAPM: Advanced Alternative Payment Model; BBA: Bipartisan Budget Act