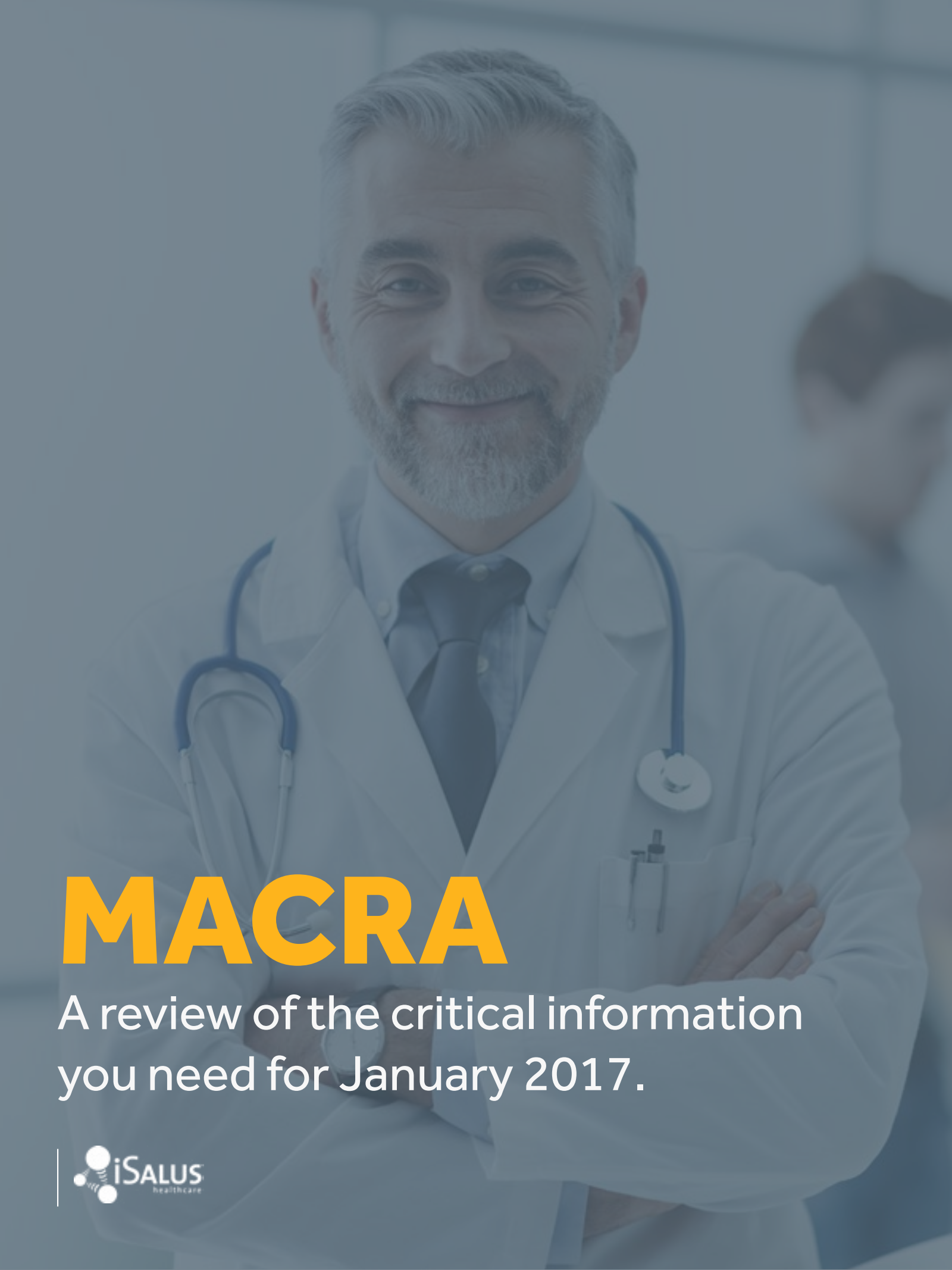


MACRA

A review of the critical information you need for January 2017.

iSALUS healthcare

MACRA

A review of the critical information you need for January 2017.

In this eBook we're going to do a high level overview of what MACRA is and why it's being put in place. Then we'll take a look at the two payment tracks: 1) MIPS, which is where everyone starts and most of us will remain; and 2) APMs. We'll also take a look at the timeline and what you can expect over the coming months

What is MACRA?

MACRA stands for *The Medicare Access and CHIP Re-Authorization Act*, and "CHIP" is the anagram for the Children's Health Insurance program.

MACRA was signed into law on April 16th, 2015. It's actually been around for more than a year although everyone is waiting for the final ruling, which will be here November 1st, 2016, after they've considered the public response that was collected until June 27th, 2016.

MACRA has multiple purposes. First, it will end the Sustainable Growth Rate (SGR). The SGR was put in place in 1997 to replace the Medicare Volume Performance Standard (MVPS) and was basically a conversion factor that was used to increase or decrease a physician's payment based on whether their Medicare payments were less than or more than the targeted Sustainable Growth Rate.

MACRA also includes funding for technical assistance to providers and funding for measure development and testing. Further, it will put in place new requirements for data sharing and some federal advisory groups. Needless to say, it's going to considerably overhaul the structure of our healthcare system.

MACRA was also created to lock in provider reimbursement rates at near-zero growth which has been presented as an annual increase of 0.5%; then for the years 2020-2025 there is zero growth; and then for 2026 and ongoing, there is a 0.25% annual increase or .75% annual increase depending on the payment track you participate in.

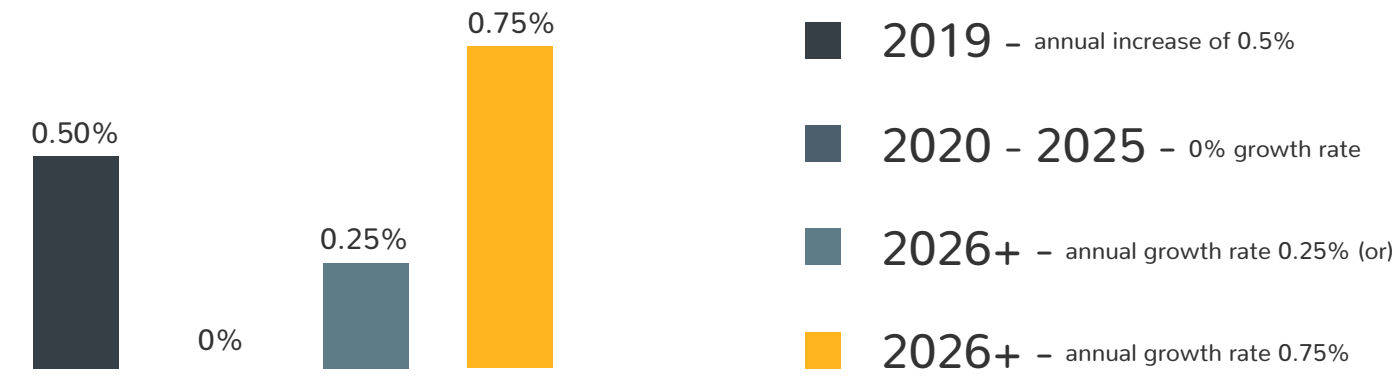


figure 1.1

Next, MACRA was created to form a new framework rewarding quality vs. quantity. It combines all current quality reporting programs like Meaningful Use, the Physician Quality Reporting System, etc., to one system that has two payment tracks which are MIPS and APMs. We'll get into those a bit deeper a little later in the eBook.

The proposed changes altogether have been named the Quality Payment Program (QPP) to replace what CMS considers this patchwork system of Medicare reporting programs with a flexible system that allows you to choose from the two paths that link quality to payments.

figure 1.2

Critical Pieces that you need to know right now include

- Performance Period 2017 – when does it start and how does it affect you
- QPP – what does it consist of and then
- MIPS
- APMs

All of this information is covered in this eBook.

Performance Period

2017 will be the performance period that CMS will use to determine a clinician's payment track and their payment adjustment under MIPS in 2019. So understand here that in the beginning, everyone will start in MIPS because there's no way to tell if you qualify for the APMs track until the data has been gathered. However, they will use the data you report in 2017 to determine your payment adjustment in 2019. So regardless of whether you'll remain in MIPS or move on to an APMs track, you need to get the practice ready to start reporting under the MIPS track in 2017 because you'll want to do the best job possible in order to avoid a negative payment adjustment in 2019

2017 Performance Period Determines

- Payment Track
- 2019 Payment Adjustment

Now let's take a look at MIPS

First, MIPS stands for *Merit-based Incentive Payment System (MIPS)*. As we saw in a previous slide MIPS is a new program that combines parts of the PQRS, Value-Based Payment Modifier and the Medicare Electronic Health Record (EHR) incentive program into one single program in which Eligible Professionals (EPs) will be measured on.

Value Based Payment Modifier

Physician Quality Reporting System

Meaningful Use/EHR Incentive

} **MIPS**

As a side note here, you'll start hearing EPs referred to as Eligible Clinicians. Where previously these programs were applied to physicians, MACRA includes a much broader range of clinicians so you'll start hearing "eligible clinicians" instead of "eligible professionals or physicians." Basically, MIPS is rolling all of these existing quality programs into what they consider a single, budget-neutral pay-for-performance program versus pay for production as some of these programs have previously been situated. And what I mean by "budget-neutral" is that CMS does not plan on doling out any more money. In fact, the reason they're tying this to quality versus production is to dole out less money. So it's going to be really important for private practices to do a great job on reporting for MACRA so that they can rank as high as possible.

Overall, what MIPS is supposed to achieve is a reduction in the number of measures clinicians are required to report on in some categories and allows clinicians the flexibility to select from a set of measures to report on based on the relevancy of the measure to their practice

Reduces Measures

Report on 6 instead of 9 Required by PQRS

Increases Flexibility

More Relevant Choices Now Available

MIPS has 4 Components that it measures

- Quality
- Resource Use
- Advancing Care Information
- Clinical Practice Improvement

Quality Category

First you have the Quality Category which has two main points we should address. The first one is that you must choose to report on six measures versus the nine that the Physician's Quality Reporting System (PQRS) currently requires you to report on. This is a big deal to the practices that were having trouble finding enough measures that their practice could show success for.

The second major point is that there are approximately 200 measures in total, 80% of which are tailored in some way towards specialists. This will offer tremendous flexibility in order to choose measures that are actually relevant to your practice.

Measures

Clinicians choose six measures versus nine measures required by PQRS

Choices

There are 200 measures to choose from & 80% of them are tailored to specialists

The Quality Category will count for 50% of your score during that first reporting year which, again, is 2017. Remember, the 2017 reporting year will affect the adjustment for 2019. This category is what is replacing the PQRS program.

So overall they are reducing the number of measures you report on and giving you more relevant measures to choose from. One thing to note is that there are guidelines as to which measures you pick. Let's take a look at those.

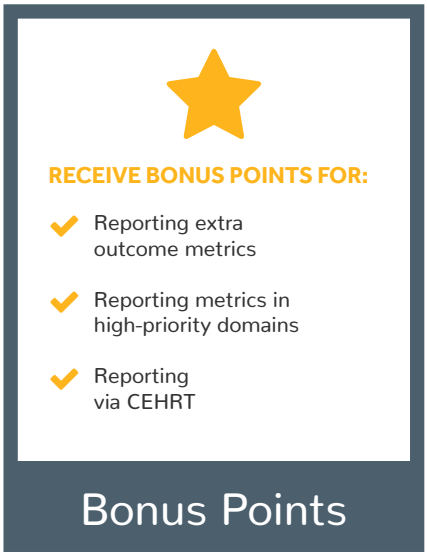
One of the six measures must be an Outcome Measure also known as a high-priority measure. In addition, one of the measures must be a crosscutting measure. Examples of Outcome Metrics are:

1. Hemoglobin A1C control
2. Depression remission at six months
3. Emergency Department visits in the last 30 days of life
4. Functional status change for orthopedic patients
5. And surgical site infections

And here, cross-cutting metrics are metrics broadly available to all clinicians with patient-facing encounters regardless of specialty. *(FYI - Telemedicine is not considered a patient-facing encounter. I know that is a trending interest right now and a lot of practices are considering adding that so, just be aware that telemedicine is not considered a patient-facing encounter)* Some examples might be:

1. Documentation of an Advanced Care Plan
2. Tobacco use screening and intervention
3. Control of high blood pressure would also be an example of a cross-cutting measure.

Finally, bonus points are awarded for reporting extra outcome metrics, reporting metrics in high priority domains (which are appropriate use, patient safety, efficiency, patient experience and care coordination) and then of course reporting via certified electronic health record technology also known as CEHRT.



In addition to the six measures your practice reports on, small practices such as individuals or groups that have up to 9 clinicians, will have two population measures calculated under MIPS by CMS. They require no additional reporting by you, but will use your claims to calculate the population measures. For groups of 10 or more clinicians CMS will calculate three population measures.

So let's break the scoring down for this category. The maximum possible points are between 80 – 90 points, based on the size of your practice:

- 9 or less clinicians can get 80 points.
- 10 or more clinicians can score 90 points.

Each measure is worth 10 points and you'll report on six measures in hopes of achieving 60 points. Then CMS will use your claims data to report on two or three more population measures. So if you have 9 or less clinicians it will be two population measures for a total of 80 points and if you have 10 or more clinicians it will be 3 population measures for a total of 90 points. That's how the Quality Category will be scored.

Cost/Resource Category

Cost/Resource Use category replaces the cost component of the Value-Based Payment Modifier. No clinician submission is required by your practice for this category. The four things to note in this category are:

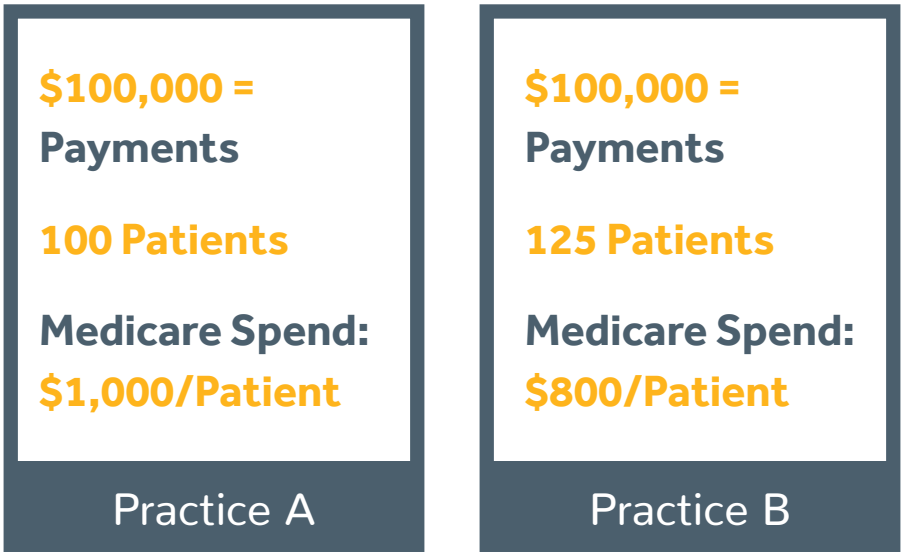
1. You'll be scored based on Medicare claims. CMS is simply going to gather the data from the claims you submit starting January 1, 2017.

2. They'll consider your total per capita costs for all attributed beneficiaries and then the Medicare spending per beneficiary. So think of it this way.

3. There will be some new episode-based cost measures for specialists

4. This category also consists of Part D costs.

We know that the "total per capita costs" can be hard to understand so consider this scenario:



If Practice A was reimbursed $100,000 by Medicare, say, in 2015. And that $100,000 was used for treating 100 patients. That means the practice was reimbursed on average $1,000 per beneficiary. On the other hand, you have Practice B that was also reimbursed $100,000 by Medicare in 2015, but their $100,000 was used for treating 125 patients, which means the practice was reimbursed on average $800 per beneficiary. So Practice B might receive a slightly more favorable score than Practice A because they're spending less money per beneficiary than Practice A is.

The Resource Use/Cost Category equals just 10% in the initial performance period but that will be growing to 30% by year 3 so be aware that they do consider this very important and it goes to show how they are going to push for more efficient but higher quality of care.

Let's reiterate you have no reporting to do. So that means they'll look at your claims, consider your per capita costs for all beneficiaries like in the example. If you're a specialist, they'll consider episode-based cost measures. In fact, this category uses over 40 episode-specific measures to account for differences among specialties.

For Cost measures, clinicians that deliver more efficient, high quality care can achieve better performance so clinicians scoring the highest points would have the most efficient resource use.

Each cost measure would be worth up to 10 points. However, Clinicians must see a sufficient number of patients in each cost measure to be scored for that measure which is generally a minimum of a 20-patient sample. The clinician's cost score would be calculated based on the average score of all the cost measures that can be attributed to the clinician. So there's not an actual number of points that you're hoping to achieve.

For example

If you have 4 measures that were worth 10 points each that means the total number of points you can score is 40.

10pts + 10pts + 10pts + 10pts
= 40 possible points

But let's say you scored 8 in the first measure, 10 in the second, only 5 in the third, and 10 in the fourth. Each individual measure would be added up and divided by 40 to get their average.

8pts + 10pts + 5pts + 10pts
= 33 points achieved

In this case that would be 33 divided by 40 which would be 0.825 or an 82.5% score in the Resource Use Category. Which means in the initial year, you would get 82.5 percent of those 10 points available or 8.25 instead of 10 points.

But what happens if you don't have at least a 20-patient sample for any of the measures in the resource use category? If that is you, and you do not have enough patient volume for any cost measures, then a cost score would not be calculated. CMS would simply re-weight the cost category to zero for you and then adjust the other MIPS performance category scores to make up the difference in the final MIPS Composite Performance Score. Again, this is not going to be a category you spend too much thinking about in the first year which is why it has the lowest weight for the overall score. Just remember in future years that will be changing and I'll show you exactly how in a few minutes.

Clinical Practice Improvement

The next category is Clinical Practice Improvement which can be broken down into three main areas. Those are:

1. Clinicians would be rewarded for practices that focused on improvement activities such as: Care coordination, Beneficiary engagement and Patient safety. Adding Chronic Care Management to your practice could potentially help you be successful in this category.

2. There are over 90 activities to choose from. Of course some are weighted heavier than others and you'll see that when you're reviewing them which will affect your choice also. Basically, you can't just choose the easy ones, because that will have an impact your overall score. The harder they are the more weight they carry so you'll likely want to have a combination.

3. Clinicians in certain APMs and qualified patient-centered medical homes receive favorable scoring. So this may or may not apply to you. There will be practices that actually do participate in some alternative payment models but do not quite reach the threshold for participating in an APM. If that's the case for your practice, there will be some options for you and we'll get to those when we learn a little about APMs.

Clinical Practice Improvement will equal 15% of your Composite Performance Score. Something to remember is that this can be reported as an individual or as a group. Now, getting to that favorable scoring that was just mentioned. Clinicians participating in medical homes earn "full credit" in this category and those participating in APMS will earn at least half credit.

You can achieve a total of 60 points for the Clinical Practice Improvement category and it's pretty simple. Pick activities that add up to a total of 60 points and report on them. If you have an activity to choose from that includes something related to Patient-Centered Medical Homes or an APM, those will be worth more points.

Advancing Care Information

Moving on now to Advancing Care Information, there are five important points to cover with regards to this category:

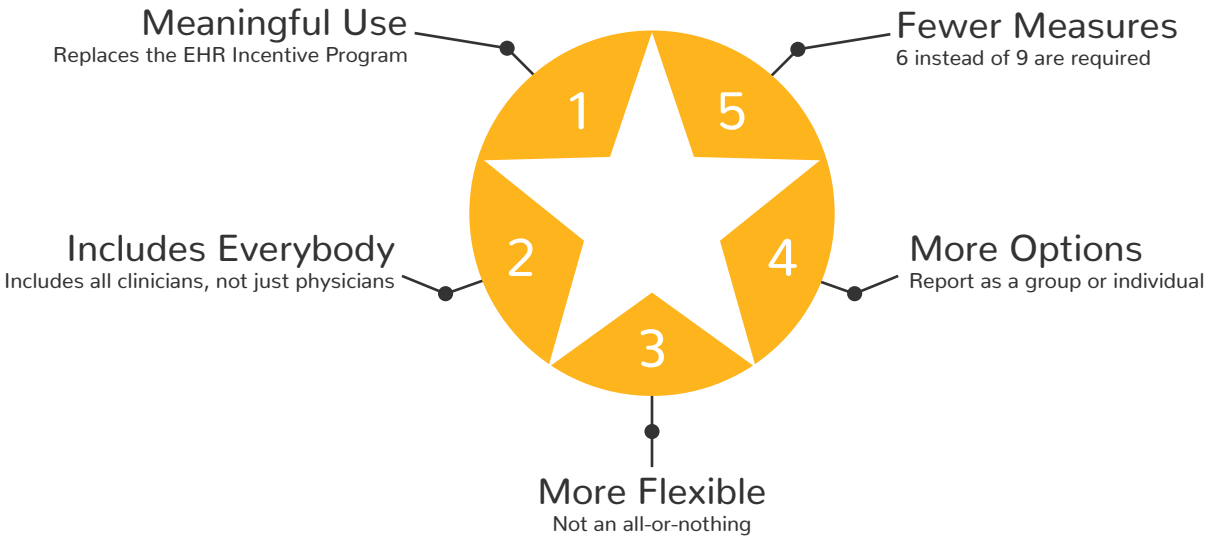
1. MIPS will replace Medicare's Meaningful Use program also known as the EHR Incentive Program for eligible clinicians. You're going to want to remember the term CEHRT or Certified EHR Technology because you're going to hear it a lot. It's extremely important that you are happy with the EHR you're using and comfortable with the fact that the vendor is going to be continuing their efforts to remain certified should any new requirements arise.

2. Everyone is included. Whereas previously it was only directed at physicians, now it includes all clinicians. (FYI, eligible clinicians include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and groups that include such clinicians. So MACRA is much broader than just a quality system for physicians.

3. It's geared towards being more flexible so it no longer is an all or nothing measure type of reporting.

4. It requires fewer measures, just 6 instead of the 9 that PQRS currently requires

5. Finally, it provides the opportunity for group practices to report as a group or they can choose for each clinician to report individually.



Now the scoring in this Advancing Care Information category is a little more involved. You can earn 25 points towards your total Composite Performance Score (CPS) in a few different ways. They split the scoring up into two parts and then threw in a potential bonus point so it can be a bit confusing.

The first part is the Base Score where you can earn up to 50 points by meeting six objectives. Then the second part of the score is the Performance Score where you can earn up to 80 points. So think of it this way, to get the full 25% you can earn from the Advancing Care Information Category, you want to earn a full 100 points.

What they've actually done is made it possible for you to earn 130 points, then they even added on an extra bonus point which you'll learn about in the MIPS webinar/eBook. So essentially you can earn up to a max of 131 points. However, if you earn more than 100 points, it doesn't affect the Advancing Care Information portion of your composite performance score. Whether you earn 100 or the full 131, you will still only receive the full 25% of that portion. As you can see, this can be pretty overwhelming which is why encourage you to continue forward after this eBook and watch the MIPS Webinar with its accompanying eBook.

One thing to note is that the weight of each category is relative over time. So the quality portion starts out being valued at 50% but by year 2021 you'll see that it's down to 30%. Whereas the Resource Use category will begin at only 10% but end up equal to quality by 2021 at 30%. However, Clinical Practice Improvement and Advancing Care Information stay the same between 2019 and 2021. So that is really important to factor in as far as where you are focusing your efforts as things get under way next year.

One of the bonuses that MIPS brings to reporting is more flexibility. Especially in the quality category where providers are only required to report on 6 metrics instead of 9 measures, like in PQRS.

(As a side note, if you're a specialist CMS specifies exceptions for certain specialties and clinicians without six applicable metrics or for those without applicable outcome metrics. The MIPS Webinar/eBook gets deeper into this)

Providers will be required to report on a minmum of 6 quality metrics (instreasd of 9 like PQRS) from over 200 options.

Chose Metrics must include **1 outcome metric** and **1 cross-cutting metric.**

6 Quality Metrics

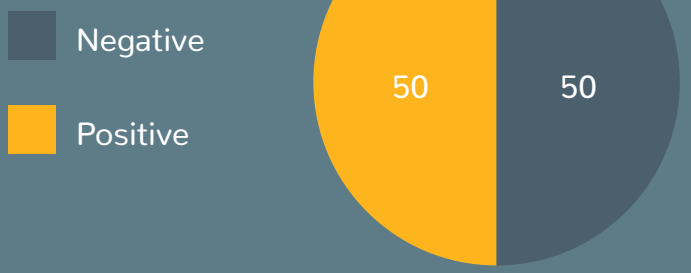
So how is that Payment adjustment determined? There's actually three parts to the determination. First, the provider is assigned a score of 0-100 based on their performance across all four categories. Second, provider score is compared to the mean or median that CMS has selected of the composite performance scores for all MIPS Eligible Clinicians with respect to a prior period specified by the Secretary. Of course, non-reporting groups are given the lowest score. And then providers who score above the performance threshold receive a bonus and those who score below the performance threshold are subject to penalty. Of course the bonus or penalty size will correspond with how far the provider deviates from the performance threshold.

Now here's why you don't have to worry so much about APMs, the highest performers in MIPS, those who exceed the 25th percentile, are eligible for an additional incentive of up to 10%. Of course that depends on how high you are in that 25% or how high above the performance threshold you landed.

Rank in the top 25%

Those who exceed the 25th percentile are eligible for bonus incentives

In order to keep the budget neutral a scaling factor up to 3x may be applied to upward adjustment to ensure the payout pool equals the penalty pool. Think of it like the curve your high school or college teacher applied so that basically the average score was passing. So they are allowed to apply that scaling factor of up the 3 x's in order to reach that budget neutrality or 0% growth that they're wanting to achieve. One more thing to note here is that CMS is going to be publishing their findings to the public. So your future scores and reporting will eventually be open to the public which could potentially have some effect on your practice if you have curious patients and you don't perform well. Hopefully, we're going to help you avoid that with webinars like this one but you're going to want to be aware of what consequences a bad performance could have.



Neutral Budget

Scaling factor applied up to 3x's towared positive

Alternative Payment Models

Now that we've had a high-level view of MIPS, let's move on to APMs. According to CMS, a Medicare APM is one of the following:

- CMMI Model Under Section 115A
- Medicare Shared Savings Porgram (MSSP)
- A Demonstration Under the Healthcare Quality Demonstration Program
- A Demonstration Required by Federal Law

CMS further states that APMs provides new ways to pay healthcare providers for the care they give Medicare beneficiaries. The examples they give include:

1. A lump sum incentive payment for some participating healthcare providers from 2019-2024
2. Increased transparency of physician-focused payment models
3. Higher annual payments for some participating healthcare providers starting in 2026.

Of course everyone that hears the "higher annual payments" part and automatically want to be in the APMs track but that's not an easy thing to achieve. Remember, you do have the ability to achieve bonuses in the MIPs track which I think is a better goal for most providers to shoot for.

So then the next question is what is an eligible alternative payment entity? Eligible Alternative payment entity means, with respect to a year, it's an entity that participates in an APM that requires participants to use certified EHR technology and provides for payment based on quality measures comparable to those in MIPS; and then also – and this is an either/or situation - either bears more than nominal financial risk for monetary losses under the APM or is a medical home expanded under CMS Innovation Center authority. And on the next slide you'll see that you'll have to have a certain percentage of patients or billing through an Eligible Alternative Payment Entity. Be sure that if you are shooting for the APM track you understand that incentive payments will only be available through the eligible alternative payment entities.

The administration is using MACRA to encourage more clinicians to participate in APMs and these eligible alternative payment entities. And if you're eligible and become qualified because you meet the threshold of payments and patients through APMs you'll only be able to be payed through an eligible alternative payment entity.

When it comes to APMs, Eligible Clinicians who are participating in APMs but do not reach the qualifying APM participant standard, which, again, I'll show you on the next slide, will still receive favorable scoring under certain MIPS categories. So in other words, if you find yourself in the MIPS track, even though you do participate in some Alternative Payment Models, because there will be some clinicians who won't have enough patients or enough billing under those APMs so if that happens to you, then understand it isn't wasted, you'll receive favorable scoring and have a better chance of ranking in that top 25th percentile in order to achieve additional bonuses

And then finally when it comes to the Administration's goals for tying payments to quality and value through APMs, in January of last year Secretary Burwell announced their goals to improve the nation's health care delivery system was to have 30 percent of traditional Medicare payments be tied to APMs by the end of this year, and 50 percent of such payments would be tied to these models by the end of 2018. So basically they are pushing for a 20% increase in APMs participation over the next 2 years. Interestingly enough, Just as a side note here, when it comes to MIPS, they want 85% participation by eligible clinicians by the end of 2018 and in the end the goal would be to have 90%. So there's a much heavier push for MIPs participation because that's where most of the private practices will end up.

Qualifying

So let's get back to qualifying. There's a difference between being an eligible clinician and qualifying professional. So you could be eligible because you participate in an eligible advanced payment entity meets the requirements we discussed on the previous slide, but in order to actually qualify for the APMs track, you have to have reached a certain threshold of patients and/or billing. Those thresholds are

01

2019-2020

To qualify for incentive payments, you must have 25% of your payments or patients through an eligible alternative payment entity

02

2021-2022

To qualify for incentive payments, you must have 50% of your payments or patients through an eligible alternative payment entity

03

2023 +

To qualify for incentive payments you must have 75% of your payments or patients through an alternative payment entity

First I need to address the Combination All-Payer & Medicare Payment Threshold options. These are additional payer arrangements that count towards becoming a qualifying APM participant aka QP. Beginning in 2021, you can also qualify as a QP for the APM track based on thresholds for combined payments from Medicare and other payers. Under this option, eligible clinicians must meet a minimum percentage (25 percent) of Medicare payments for covered professional services or patients through an eligible alternative payment entity and the overall threshold through other payer arrangements that have similar requirements to those for eligible alternative payment entities. That percentage varies depending on the year but will range between 50-75%. So this option will also be available for the APMs track.

01

25%

EPs must meet minimum 25% of Medicare payments for covered professional services or patients through an eligible alternative payment entity

02

Overall Threshold (50% - 75%)

The overall threshold must be met through other payer arrangements that have similar requirements to those for eligible alternative payment entities.

Now I want to get back to the partial qualifying APM Participant because this might actually apply to some of you attending today. Again, they participate in an APM but don't qualify because they don't meet the threshold percentage for that particular year. What CMS offers to them is the option of participating in MIPs or not. So they have choice. Either way, they're not going to receive the 5% APM incentive payment. But if they do choose to participate in MIPS, they'll receive favorable scoring and will have a better chance at ranking in the top 25th percentile and achieve bonuses that way. If they don't choose to participate in MIPs, they will have no payment adjustment for that year. So there is some benefit to at least be a partially qualifying APM Participant

0%

Payment Adjustment

A partial QP is defined as an EP who does not meet the thresholds established for a qualifying APM participant but meets slightly reduced thresholds.

Partial QPs do not receive the 5 percent APM incentive payment, but they can choose whether or not to participate in MIPS. If they choose not to report to MIPS, they will have no payment adjustment for that year.

So we're getting close to being done now and I'm sure some of you are thinking, "How will I know what track I qualify for. Here's what you're going to ask yourself, and remember, you won't start the Performance Year 2017 knowing which track you'll end up in. That's why everyone is starting in MIPS. But these are the questions you'll want to ask yourself when the time comes.

1. First, if you participate in an Advanced APM do you meet the Qualifying Participant Threshold of 25% of payments or 20% of patients tied to an Advanced Alternative Payment Model in 2017? If the answer is yes, you can participate in the APM track.

2. If you do not meet the QP threshold ask yourself – do I meet the Partial QP threshold which for 2017 will be 20% of payments or 10% of patients tied to an Advanced APM? If so, you can optionally choose to be exempt or participate in the MIPS APM Scoring Standard which is the favorable scoring mentioned earlier in this eBook.

3. If you do not participate in an Advanced APM, ask yourself - do I participate in any Alternative Payment Model that perhaps doesn't qualify as advanced, but does qualify me for favorable scoring under MIPS? If yes, you are also eligible to participate in the MIPS APM Scoring standard – which is more favorable because you're participating in an APM that carries more weight.

4. Finally, if you do not participate in an Advanced APM and do not qualify to participate in a MIPS APM, then there is no question to ask, you will definitely be on the regular MIPS track. This is where the majority of clinicians will be as you would already need to be participating in an APM prior to January 1, even if it doesn't qualify as Advanced, in order to establish during the performance period that you meet the threshold. So if you're not currently participating in an APM then the track is obvious, it's going to be MIPS. However, in future years you can begin participating in an APM or Advanced APM and qualify for that track later on.

So who is excluded from participating altogether? That's where everybody wants to be right?

Patient Volume

Clinicians or groups who have less than or equal to 10,000 in Medicare charges and less than or equal to 100 Medicare patients are excluded from the MIPS payment adjustment.

New Provider

A provider in their first year of billing Medicare do not have to worry about MIPS until after their first year is completed.

Partial Qualify Participant

Meets lower APM threshold and has a choice to participate using MIPS APM scoring or not participate at all but receive no negative adjustment.

There's three categories of clinicians who will be excluded those are

1. Clinicians or groups who have too low of patient volume which is $10,000 or less in payments and 100 or less patients.

2. New providers are also excluded at first, until they have a full year of Medicare billing under their belt in order for CMS to have their data and then they'll have to start the MIPS track.

3. And then remember that partially qualified participant under APM who met a lower threshold will have the option to participate or not.

To wrap up this eBook, let's take a look at the timeline ahead:

On June 27th CMS closed public comments to begin reviewing the data. After CMS examines the information to decide what changes, if any, need to be made to the Final Rule, which we are supposed to be getting on November 1st. (Be sure to look for our upcoming webinar/eBook about the Final Rule!).

June 27, 2016

Public Comment

Comment period on proposed rule closes

November 1, 2016

Final Rule

CMS has a goal of releasing the final rule for the first year of MIPS and APM tracks this fall.

What's our advice? **Do not wait to start getting ready**. Once that final rule is released, you'll only have the month of November because we all know how crazy the holidays get after Thanksgiving. You do not want to be scrambling around during the holidays.

After the final rule is released the performance period will begin on January 2017 and everyone will begin reporting under the MIPS track while CMS begins to gather data. And then based on what you report in 2017 the payment adjustment will take place in January 2019.

January 2017

Performance Period

Performance Period begins. CMS will use this data to determine your eligibility for MIPS or APM tracks

January 2019

Payment Adjustment

First year of physician payment adjustment under MIPS or APM