MACRA

QUESTIONS & ANSWERS

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WHAT IS MACRA?

On October 14, 2016, the Department of Health and Human Services (HHS) issued its final rule with comment period implementing the Quality Payment Program (QPP) that is part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

This bipartisan approved law dramatically impacts the way Medicare payments will be made as the healthcare industry shifts from fee-for-service to value-based care.

Under value-based care, clinicians provide a service and their payment varies based on how well they meet certain quality measures and create value for their patients. The Quality Payment Program's (QPP) purpose is to provide new tools and resources to give patients the best possible, high-quality care.

The QPP consists of two major tracks:

- The Merit-Based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (Advanced APMs)

WHAT IS MIPS?

Merit-Based Incentive Payment System (MIPS) – a new program for certain Medicare-participating eligible clinicians that consolidates three current quality reporting programs: Physician Quality Reporting System (PQRS), Physician Volume-based Payment Modifier (VM), and Meaningful Use (MU).These existing 3 programs will be phased out by the end of 2018 with components of these included in MIPS through MACRA legislation. MIPS is a streamlined performance reporting system, which should be more easily managed than the existing multiple reporting systems. Under this program, CMS will score clinicians based on their performance in four categories: Quality, Cost, Improvement Activities (IA), and Advancing Care Information (ACI).

WHO WILL/WILL NOT PARTICIPATE IN MIPS?

CMS estimates that approximately 712,000 clinicians will be affected by QPP changes in the first performance year (2017). However, not all clinicians will be subject to these changes.

For performance years 2017 and 2018, the following providers are considered MIPS Eligible Clinicians (ECs):

- Physicians (MD/DO/DMD/DDS)
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists

For performance years 2017 and 2018, the following providers are considered excluded MIPS ECs:

- Newly Medicare-enrolled MIPS eligible clinicians
- Advanced APM Qualifying Participants (QPs)
- Certain Partial QPs

- Clinicians falling under the low-volume threshold, defined as clinicians or groups with $30,000 or less in Medicare charges **OR** 100 or fewer Medicare patients
  - To be eligible for MIPS, a clinician must bill >$30K **AND** see >100 Medicare beneficiaries.
    - "**AND**" is the key to eligibility
    - "**OR**" is the key to exclusion

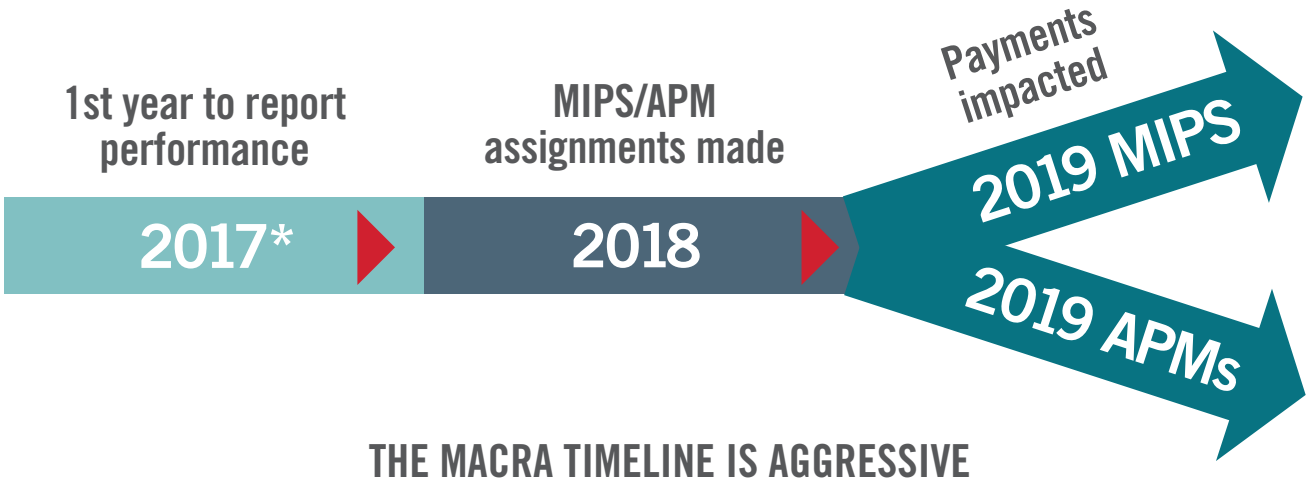
In addition, Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) may be excluded from MIPS. All payments for services made under FQHC and RHC all-inclusive payments are exempt from MIPS. However, any Medicare Part B items and services provided and billed outside of all-inclusive payments will be subject to MIPS adjustments.

WHAT IS THE MIPS TIMELINE(S) OR WHEN WILL IT BE IMPLEMENTED?

The timeline for the MIPS rulemaking process leading up to the launch of the program on January 1, 2017:

- April 16, 2015 – MACRA enacted
- April 27, 2016 – CMS released proposed MACRA rule containing MIPS regulations
- October 14, 2016 – MACRA final rule published, clarifying the Quality Payment Program
- January 1, 2017 – First MIPS performance year begins
- October 2, 2017 – Deadline to begin collecting "consecutive 90-Day performance" data and still could qualify for a small positive payment adjustments for performance year 2017.

For MIPS, clinician performance data for the Advancing Care Information, Quality, and Improvement Activities categories for a performance year are generally due to CMS by March 31st of the following calendar year.



THE MACRA TIMELINE IS AGGRESSIVE

Performance Year 2017 is used to determine clinician payment adjustments in 2019.

* Providers may not be certain which track they will fall into when reporting in 2017.

WHAT'S THE FINANCIAL IMPACT OF MIPS?

MIPS will have both short- and long-term financial impact – from the selection of specific quality measures, to the option of reporting as a group or as individual ECs. The composite performance score (CPS), which is made up of the MIPS performance categories, will impact Medicare reimbursement by a positive, neutral, or negative payment adjustment. Depending on the CPS and reporting option chosen, reimbursement for Medicare services, as well as provider compensation, may be impacted as a result of MIPS.

CMS estimates approximately 592K and 642K eligible clinicians will be required to participate in MIPS in its transition year. With a focus on high-quality and low-cost care, ECs will have an opportunity to earn substantial bonuses under MIPS.

- Assuming 90% of eligible clinicians of all practice sizes participate in the program, estimate MIPS payment adjustments will be approximately equally distributed between negative MIPS payment adjustments ($199 million) and positive MIPS payment adjustments ($199 million) to MIPS eligible clinicians, to ensure budget neutrality. [1]
  - Positive MIPS payment adjustments will also include an additional $500 million for exceptional performance payments to MIPS eligible clinicians whose performance meets or exceeds a threshold final score of 70.
- 2017 performance year/2019 payment year – +/- 4%
- 2018 performance year/2020 payment year – +/- 5%
- 2019 performance year/2020 payment year – +/- 7%
- 2020+ performance years/2022+ payment years – +/- 9%

WHAT ARE THE MIPS REPORTING REQUIREMENTS?

ECs participating in MIPS will earn a performance-based payment adjustment to Medicare payments based on evidence-based and practice-specific quality data reported in the following four MIPS performance categories:

1. **Quality**

   For performance year 2017, the quality category is 60% of the CPS. To fully participate, ECs will need to report 6 measures, covering any 90 days, including at least one outcome measure, if available, or one specialty-specific measure set. ECs should review quality measures in order to choose the most impactful measures and focus on earning bonus points to increase the performance score in this category.

2. **Cost**

   - The cost category is 0% of the CPS for performance year 2017. There is no reporting requirement in this category because ECs will be assessed on Medicare claims data, Although this performance category is not part of the CPS until performance year 2018, CMS plans to calculate the following two measures based on 2017 performance and provide feedback to ECs:
   - Total per capita costs for all attributed beneficiaries
   - Medicare Spending per Beneficiary (MSPB)

[1] *Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models. (4 November 2016). https://www.federalregister.gov/documents/2016/11/04/2016-25240/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm.*

3. **Improvement Activities**

   For performance year 2017, the improvement activities category is 15% of the CPS. To fully participate, ECs will need to attest completion of up to 4 activities that improve clinical practice for a minimum of 90 days. There is special consideration for practices with less than or equal to 15 ECs, providers in rural or geographic HPSAs, non-patient facing providers, and APM participants. In order to increase the performance score in this category, ECs should identify the easiest path to 40 points, which is the highest possible score in the improvement activities category.

4. **Advancing Care Information**

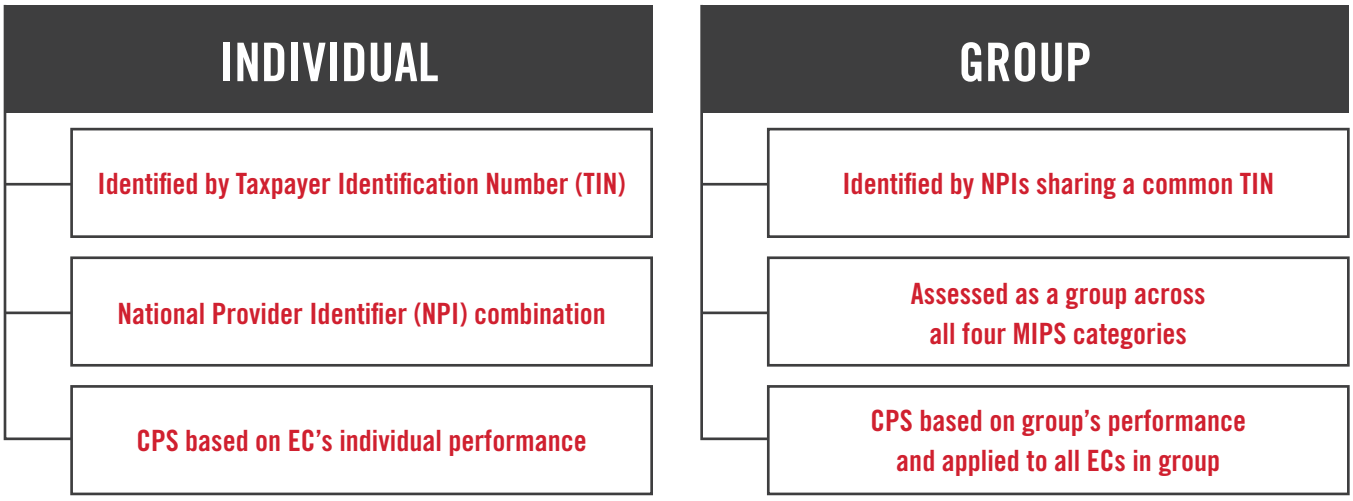
   The advancing care information category is 25% of the CPS for performance year 2017. ECs will be required to fulfill the measures in the base score in order to meet the performance threshold in transition year 2017. In addition, ECs may choose to submit up to 9 measures for the performance score as well as earn bonus points in this performance category. One way for ECs to increase the performance score in the advancing care information category is to focus on earning performance score points in addition to fulfilling the measures in the required base score.

For the 2017 transitional year, ECs may pick-the-pace of reporting under MIPS in order to avoid a negative payment adjustment in 2019, as follows:

1. **Submit something (0%)**
   - At least 1 quality measure, 1 improvement activity, OR 5 required ACI measures
   - Test system for broader participation in future years ('18-'19)
2. **Submit a partial year (+%)**
   - Submit data for reduced period – at least 90 days – >1 quality, >1 improvement activity, or > 5 required ACI measures
   - Eligible for neutral or small + payment adjustment
3. **Submit a full year (+%)**
   - Full year participation begins as early as 1.1.17 (report full 12 mos) or any 90-day period for all required measures in all performance categories
   - Eligible for moderate + payment adjustment
   - Exceptional performers eligible for additional + adjustment

If MIPS ECs choose not to report even one measure or activity, they will receive the full negative 4 percent adjustment in 2019 based on 2017 performance period.

WHAT IS THE DIFFERENCE IN GROUP VS INDIVIDUAL REPORTING?



Under MIPS, clinicians can submit performance data as an individual, a group, or an APM entity. However, they must report the same way across all four categories.

Individual

- If submitting MIPS data as individual, payment adjustment will be based on the individual provider's performance.
- Individual is defined as a single National Provider Identifier (NPI) tied to a single Tax Identification Number (TIN).
- Send individual data for each of the MIPS categories through an electronic health record (EHR), registry, or qualified clinical data registry (QCDR).
- May also send quality data through your routine Medicare claims process.

Group

- If submitting MIPS data with a group, the group will receive one payment adjustment based on the group's performance.
- Group is defined as a single TIN with two or more MIPS eligible clinicians, as identified by their individual NPI, who have reassigned their Medicare billing rights to the TIN, no matter the specialty or practice site.
- Group will send in group-level data for each MIPS category through the CMS Web Interface – Group Practice Reporting Option (GPRO) or an EHR, registry, or a QCDR.
- If your group wants to use beneficiary-level sample reporting, your group should have registered to use the CMS Web Interface by June 30, 2017.

When determining whether to report individually or as a group, you should consider the following:

- The TIN drives the reporting option – if an entity has several providers but only one TIN, then all the ECs must report individually, or all the ECs must report together as a group.

- An example of how this can get extremely complex includes a multi-specialty clinic with 10 providers – 5 primary care & 5 specialists. The clinic has only one location and a single TIN. Because the primary care providers will have similar MIPS goals, the clinic would like to report the 5 primary care providers as a group, with the remaining 5 specialists reporting individually. Because there is only one TIN for the clinic, all 10 providers have to report together as a group, or all 10 have to report individually. A strategic solution could be that the clinic applies for another TIN so that the primary care physicians can report as a group under the original TIN, and the remaining 5 specialists can report individually under the new TIN.

- An EC reporting as an individual is scored based on his/her individual performance and receives a CPS that is unique to him/her. This CPS will be tied to the individual EC and publicly posted.
- ECs reporting together as a group will be scored based on the group's performance and will receive a single CPS that will be applied to each individual EC in the group. A few things to keep in mind are that high-performing ECs could raise the group CPS as well as low-performing ECs could lower the group CPS. Estimating the performance of ECs is important when determining whether to report individually or as a group.
- Keep in mind EHR and other system capabilities when determining what data will need to be obtained in order to report for ECs. Multiple EHRs and/or systems may cause an administrative burden when identifying measures and obtaining data for reporting purposes.

HOW DO I PREPARE FOR MIPS?

Checklist for determining readiness for MIPS participation:

1. Make sure that your EHR is certified by the Office of the National Coordinator (ONC) for Health Information Technology to ensure readiness for capturing information for MIPS ACI category and certain measures for quality category.
2. Identify MIPS measures and activities that best fit your practice.
3. Determine submission method. Consider using a registry or QCDR to extract and submit quality data.
4. Decide whether to report as an individual EC or with a group.

WHAT ARE APMS?

APMs are new payment and service delivery models that provide incentive payments for participation in an innovative payment model focused on better care and smarter spending by allowing physicians and other clinicians to deliver high-quality and cost-effective care to their patients. Developed in partnership with the clinician community, APMs may apply to specific clinical conditions, care episodes, or populations. Care provided to patients is coordinated among clinicians and customized for patients within a streamlined payment system. The CMS Innovation Center is responsible for developing these new payment and service delivery models.

WHAT'S THE DIFFERENCE BETWEEN AND APM AND AN ADVANCED APM?

Advanced APMS are a subset of APMS and let practices earn more for taking on some risk related to their patients' outcomes.

- May earn 5% incentive payment (during 2019 through 2024 and be exempt from MIPS reporting requirements and payments adjustments) by going further in improving patient care and assuming risk through an Advanced APM.

It's important to understand that QPP does not change the design of any particular APM. Instead it creates ***extra incentives*** for a sufficient degree of participation in Advanced APMs.

Advanced APMs ⇒ Advanced APM-specific rewards + 5% lump sum incentive

HOW DO I PARTICIPATE IN APMS?

APMs that meet criteria to be Advanced APMs provide the pathway through which eligible clinicians, who would otherwise participate in MIPS, can become Qualifying APM Participants (QPs), and therefore, earn incentive payments for their Advanced APM participation.

In order to qualify for the 5% APM incentive payment for participating in an Advanced APM during a payment year and be excluded from MIPS, a QP must receive a certain percentage of payments for covered professional services or see a certain percentage of patients through the Advanced APM during the associated performance year.

Participate in Advanced APM path and earn 5% incentive payment in 2019 if:

- Receive 25% of Medicare payments (payment amount method)

  OR

- See 20% of Medicare patients through an Advanced APM in 2017 (patient count method)

If individual eligible clinician who participates in multiple Advanced APM Entities does not achieve QP status through participation in any single APM Entity, CMS will assess the eligible clinician individually to determine QP status based on combined participation in Advanced APMs

WHAT ARE THE RISKS OF PARTICIPATING IN APMS?

Clinicians & practices can receive greater rewards for taking on some risk related to patient outcomes.

The total amount of risk must be equal to at least either:

1. 8% of average estimated Med Parts A & B revs of participating APM entities; or
2. 3% of expected expenditures for which the APM Entity is responsible.
   - During specific time periods, CMS will compare expected and actual expenditures. If actual expenditures exceed expected, a penalty--in the form of withheld or reduced payment – is applied or a payment is owed to CMS.

WHAT ARE ADVANCED APM REPORTING REQUIREMENTS?

In order to qualify as an Advanced APM, 3 criteria must be met:

1. The APM requires participants to use CEHRT
2. The APM bases payments on quality measures comparable to those in the MIPS quality performance category; and
3. The APM either (1) requires APM entities to bear more than nomincal risk for monetary losses; or (2) is a Medical Home Model expanded under CMMI authority.

HOW DO I KNOW WHICH ADVANCED APM TO PICK?

Conduct risk analysis of various APMs available to the organization, with alignment of short term and long term strategies related to the organization's goals.

CMS has outlined the following models as Advanced APMs:

- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Oncology Care Model (OCM) - Two-Sided Risk
- Shared Savings Program - Track 2
- Shared Savings Program - Track 3
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT)

HOW DO I KNOW WHICH TRACK I FALL INTO?

You need to understand the thresholds for participation in MIPS and APMs:

- Participate in MIPS if you decide to participate in traditional Medicare Part B, rather than an Advanced APM, and you bill Medicare more than $30,000 a year and provide care for more than 100 Medicare patients a year
- Participate in an Advanced APM path and earn 5% incentive payment in 2019 if you are considered a QP and meet the following participation requirements:
  - Receive 25% of Medicare payments (payment amount method)

    OR

  - See 20% of Medicare patients through an Advanced APM in 2017 (patient count method)

Final Rule (10.14.16) established the Quality Payment Program (QPP) and its two interrelated pathways, or track options:

- **Merit-based Incentive Payment System (MIPS)** – traditional Medicare Part B (performance-based payment adjustment)
  - Participate in MIPS if you decide to participate in traditional Medicare Part B, rather than an Advanced APM.
  - Earn a performance-based payment adjustment to your Medicare payment
  - Based on evidence-based and practice-specific quality data
  - Provide high quality, efficient care supported by technology by sending in information in 4 performance categories.
- **Advanced Alternative Payment Models (APMs)** – incentive payment for participating in an innovative payment model
  - Participation requirement – 2-sided risk with quality measurement
    - *Will need to send in quality data required by Advanced APM – may be found on model's website (qpp.cms.gov)*
  - Earn 5% incentive payment for Advanced APM participation if following participation requirements met (see chart below for actual % amounts):
    - Receive XX% of Medicare Part B payments through an Advanced APM

    OR

    - See XX% of Medicare patients through an Advanced APM

PARTICIPATION PERIOD	PAYMENT PERIOD	PAYMENT	PATIENT
2017 – 2018	2019 – 2020	25%	20%
2019 – 2020	2021 – 2022	50%	35%
2021 – Beyond	2023 – Beyond	75%	50%

  - If leaving an Advanced APM during 2017, make sure enough patients (20%) are seen or received enough payments (25%) through an Advanced APM to qualify for 5% bonus. If these thresholds are not met, submitting MIPS data to avoid a downward payment adjustment may be needed.