MACRA: What Physicians Need to Know

Massachusetts Medical Society
Town Hall
December 2, 2016

MACRA
Medicare Access and Chip Reauthorization Act
PL 114-110

- Replaces SGR permanently & stops annual 25-30% cuts to Medicare
  - Retains Fee for Service - modified
  - Physician Choice and Involvement
  - Transitional payment methodology

- Supported by the AMA and vast majority of national and state medical and specialty societies
MACRA

- Big picture – the final rule provides much more flexibility, more time to implement, less reporting burdens and more options

- CMS Acting Administrator Andy Slavitt: “Goal is patient centered, physician focused”

THE QUALITY PAYMENT PROGRAM
I. MIPS
MIPS Performance Categories

A single MIPS composite performance score will factor in performance in 4 weighted performance categories on a 0-100 point scale:

- Quality (former PQRS)
- Resource use (former value based modifier)
- Improvement activities (new)
- Advancing care information (former MU)

MIPS Composite Performance Score (CPS)
Who Will Participate in MIPS?

Affected clinicians are called “MIPS eligible clinicians” and will participate in MIPS. The types of Medicare Part B health care clinicians affected by MIPS may expand in the first 3 years of implementation.

Years 1 and 2

- Physicians (MD/DO and DMD/DDS), PAs, NPs, Clinical nurse specialists, Nurse anesthetists

Years 3+

- Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals

Secretary may broaden Eligible Clinicians group to include others such as

Who will NOT Participate in MIPS?

There are 3 groups of clinicians who will NOT be subject to MIPS:

FIRST year of Medicare Part B participation

- Below low patient volume threshold:

- ELIGIBLE Alternative Payment Models

- Medicare allowed billing charges ≤ $30,000 annually or provides ≤ = 100 Medicare patients.

Note: MIPS does not apply to hospitals or facilities
MIPS – Reporting Options for Eligible Clinicians

Eligible Clinicians can participate in MIPS as an:

- Individual
- Group

Or

A group, as defined by taxpayer identification number (TIN), would be assessed as a group practice across all four MIPS performance categories.

Note: "Virtual groups" will not be implemented in Year 1 of MIPS.

How to Report

Report as an Individual
The Individual, defined as a single Tax ID and single NPI, report through any of the following:
- Electronic Health Record
- Registry
- Qualified Clinical Data registry.
- Quality data through Medicare claims process.

Payment adjustment sent to the individual

Report as Group
The group, identified as has one tax ID, submits group level information through any of the following:
- Electronic Health Record
- Registry
- Qualified Clinical data Registry
- CMS web interface

One payment adjustment sent to the group
MIPS Reporting 2017 – Quality

For a positive update:
- Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days, or
- Report a Specialty set or subspecialty for a minimum of 90 days.

Bonuses available for reporting through EHR, qualified registry, QCDR, or web interface.

2017 Performance Category Weights for MIPS

- Quality: 60%
- Advancing Care Information: 25%
- Improvement Activities: 15%
- Cost: 0%
MIPS Reporting 2017 – Improvement Activities

**Improvement Activities**

**New Category**

- Expanded Practice Access;
- Care coordination,
- beneficiary engagement,
- population management,
- health equity

**For a positive update:**

- Attest that you have completed up to 4 out of 90 improvement activities in 90 days

- No required categories: includes AMA Steps Forward

- Reduced requirements for Small practices in Rural or HSAs: attest completion of 2 activities in 90 days

- Medical homes are exempted

**2017 CATEGORY WEIGHT 15%**

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**Improvement Activities Categories**

- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary Engagement
- Patient Safety & Practice Assessment
- Achieving Health Equity
- Emergency Response and Preparedness
- Integrated Behavioral & Mental Health
## MIPS Reporting 2017 – ACI

**Advancing Care Information**
(Formerly Meaningful Use)

- Fulfill the 4 out of 5 required measures for a minimum of 90 days for a positive update:
  - Security Risk Analysis
  - E-Prescribing
  - Provide Patient Access
  - Send Summary of Care
  - Request/Accept Summary of Care

Choose to submit up to 9 measures for a minimum of 90 days for additional credit.

**OR**

You may not need to submit Advancing Care Information if these measures do not apply to you.

| 2017 CATEGORY WEIGHT 25% |

## MIPS Reporting 2017 – COST

**COST**
Replaces the Value Based Modifier

- No reporting is required. CMS collects information from adjudicated claims.

**Note:** CMS will not use the Cost category for payment in 2019 but will calculate performance based on cost for feedback to clinicians. CMS will also calculate total per capita costs for all attributed beneficiaries.

| 2017 CATEGORY WEIGHT 0% |

Weighting for cost increases in later years to 30%
Tip: Find a registry
Easier to report: bonus points


Points, Percentages and Performance Thresholds

Points
- Each MIPS category is assigned points.
- When QPP is fully implemented, 100 points will be required for the full update for that year. For 2017, 3 points are required.
- There are well over 100 points possible in the four categories to give MDs flexibility and options as well as Bonus points.

Percentages
- Refers to the weighting of each MIPS category, e.g., Quality 60%. Will change over time.

Performance Thresholds
- Determined annually by CMS based on the previous experience
“Non Patient Facing” Clinician

- Includes, anesthesiologists, pathologists, radiologists
- Exempted from MIPS if you bill 100 or fewer Medicare patient facing encounters (includes telehealth)
- For groups, more than 75% billing under the group TIN meet the definition
- Term “non patient facing” is being revisited

Low Volume Exclusion

- Eligibility for low-volume exclusion to be calculated by CMS
  - Notification should occur in December 2016
  - Based on 12-month historical data (September 2015 - August 2016)
  - Includes Part B drug costs, but not Part Don TIN/NPI
- Qualifying individuals may volunteer to report, but they will not be eligible for pay adjustments
Small Practice Issues

- In 2017, CMS estimates
  - About 32.5% of clinicians will be exempted. Represents 5% of Medicare Part B spending
  - 90% of eligible clinicians will get zero or positive adjustments
  - 80% of those will be in groups ≤ 10

- Eased requirements for MIPS reporting

- $100 million in grants for technical assistance to small practices via QIOs, regional health cooperatives, etc.

- Future rulemaking to address virtual groups, pooled financial risk arrangements

Payment under MIPS

$\text{RVU} \times \text{Conversion factor} \times \text{MIPS Composite Performance Score} + = \text{Medicare Reimbursement}$

2019 Bonus up to 4% or down to 4% (Budget neutral)

Bonus/penalty increases 5% in 2020, 7% in 2021 and 9% in 2022 and thereafter

Additional $500 million bonus pool for high performers (not budget neutral)
II Alternative Payment Models
APMs

Statute defines APMs as:

1) Require participants to take on more than “nominal risk”
2) Require percentage of participants to use certified EHRs;
3) Base payments on quality metrics similar to MIPS;
4) Medical homes as qualified by the CMMI

Advanced APMs and Other APMs

- Advanced APMs - Receive 5% bonus payments - exempt from MIPS
  - Bear "more than nominal risk"
  - Certified EHR’s = 50% of eligible (Year 2: 75% eligible clinicians)
  - Use Metrics similar to the MIPS: but do not need to report under MIPS

- MIPS APMS
  - Will be scored using APM methodology (easier)

- Qualified Medical Homes (can qualify as Advanced APMs)
  - Lower Financial risk requirements than regular Advanced APMs

- Physician Focused Payment Models
  - To be recommended by the Physician Technical Advisory Committee
Advanced APMs

Definition of nominal risk

- 8% of revenues when Medicare expenditure are higher than expected, or
- 3% of total Medicare expenditures, when Medicare expenditures are higher than expected – whichever is lower

Qualified Providers: Participants in an Advanced ACO who meet either of the following criteria:
- 2019 – 25% payments at risk or 20% of patient
- 2022 -75% payments at risk or 50% of patient

Qualified providers receive the 5% bonus payment

Advanced APMs - 2017

APMs "incentivize quality and value " and include:
- The Medicare Shared Savings Program ( Track 2 & 3)
- Next Generation ACO model
- Comprehensive ESRD Care
- Comprehensive Primary Care Plus ( CPC +)
- Oncology Care Model ( 2 sided risk – 2018)

Qualified Medical homes, as expanded by the CMMI.
Advanced APMs 2018

Final rule – expands definition of advanced APMs

- ACO Track 1 +
- New Voluntary Bundled Payment Model
- Advancing Cardiac Care through Episode Payment Models
- Reviewing expanding existing Advanced APM models by 1/2017

*Of note, Track 1 Shared Savings are not included*

Payment under APMs

- Advanced APMS and Qualified Medical homes receive whatever the APM contract stipulates + 5% annually until 2025 (work with Congress to extend)

- MIPS APMs, Partially Qualified APMS – eligible for MIPS bonuses but do not receive automatic 5%.

- Bonus payments eligible for high performers.

CMS estimates CMS expects 70,000 – 120,000 to qualify in 2017 with incentive payment between $331 million & $571 million in 2019. In 2018, expect between 125,000- 250,00 to qualify
When will these Quality Payment Program provisions take effect?

Getting Started: The Transition Year 2017 “Pick Your Pace”

- 2017 is a transition year and performance period for both MIPS and APMs. Payment in 2019 will be based on work in 2017.

- 2018 may also be a transition year. Payment in 2020 will be based on work in 2018.

Andy Slavitt “Ultimately we are not looking to transform the Medicare program in 2017. We are looking to make a long-term program successful”
Pick your Pace 4 options + one

- Initiate a “test period” – Report at least one measure for one patient – no penalty
- Partial year reporting – begin when you choose for at least 90 days – report one or more measures on your patients – potential for positive update
- Full year reporting – potential for maximum bonus
- Qualify as an APM - exempt from MIPS - get 5% bonus

+ one

If you are not exempt and you choose to do nothing,

You will be penalized 4%, which increases annually
But you decide when to start reporting

- Pick your own Pace
  - If ready, start January 1, 2017
  - If not, start anytime between January and October 2017
  - Data must be to CMS by March 31, 2018

### Pick your Pace Bonus Options

<table>
<thead>
<tr>
<th>Option</th>
<th>No reporting</th>
<th>Test</th>
<th>Partial</th>
<th>Full</th>
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<tbody>
<tr>
<td>At least one measure</td>
<td>No cut</td>
<td>90 days of reporting</td>
<td>Potential +$</td>
<td>Potential full 4%+</td>
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<tr>
<td>Exceptional performers eligible for additional positive adjustment each year for 5 years</td>
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CMS is exploring ways in the future to shorten time period between performance period, feedback and payment.
Timelines for payment and updates

Performance year for both MIPS and Advanced APMs starts in January 2017 for payments in 2019.

For each year from 2019 – 2023 there is a $500 million bonus pool for exceptional performance. Bonus is in addition to payment adjustment.

MACRA in a Minute

The 2 minute version or.....

what the heck did she just say?
When does MACRA take effect?

The program begins Jan. 1, 2017, but if you are not ready by then, you can choose to start collecting performance data as late as Oct. 2, 2017. Whenever you start, performance data is due by March 31, 2018.

Excerpted from Medical Economics, “6 things Doctors Need to know About MACRA”

Who Does not have to participate?

If you are in your first year of taking Medicare Part B, OR
Your allowed charges are less than $30,000 annually OR
You provide care to less than 100 Medicare patients each year, OR
You qualify for an advanced APM or qualified medial home, then

You are exempted from the new MIPS reporting.

Modified from Medical Economics, “6 things Doctors Need to know About MACRA”
Why are there different start dates?

To make it easier for practices to comply with MACRA, CMS created four options, each with its own requirements.

**Option 1:** Test the quality payment program. As long as you submit some data—for example, one quality measurement or one improvement activity—you can avoid a downward payment adjustment. You need to start collecting data no later than Oct. 2, 2017.

**Option 2:** Participate for part of the year. If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small payment adjustment. You must start no later than Oct. 2, 2017.

**Option 3:** Participate for the full year. If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment. You must start collecting data Jan. 1, 2017.

**Option 4:** Participate in an Advanced Alternative Payment Models in 2017. Instead of reporting quality data and other information, the law allows physicians who qualify in Advanced Alternative Payment Models, such as a Qualified Medical Home, to automatically receive a 5% incentive payment in 2019.

Regardless of which option you choose, to earn the possible positive payment adjustment that starts Jan. 1, 2019, all 2017 data must be submitted by March 31, 2018.

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Start dates, cont.

**Option 3:** Participate for the full year. If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment. You must start collecting data Jan. 1, 2017.

**Option 4:** Participate in an Advanced Alternative Payment Models in 2017. Instead of reporting quality data and other information, the law allows physicians who qualify in Advanced Alternative Payment Models, such as a Qualified Medical Home, to automatically receive a 5% incentive payment in 2019.

Regardless of which option you choose, to earn the possible positive payment adjustment that starts Jan. 1, 2019, all 2017 data must be submitted by March 31, 2018.
WHAT Happens if I ignore MACRA

If you don’t send in any data, you will receive a negative 4% payment adjustment in 2019 which increases each year thereafter.

What if I am in an ACO, IPA, PHO, or a Medical home and I am really good at this reporting risk stuff?

You will want to see if your group qualifies as an advanced APM. If you are a qualified provider, you do not have to report under the MIPS system and you will automatically qualify for a 5% update. (Option 4)
1. Do I have to have an EMR to participate?

No. You will not be eligible for the full bonus updates because of the ACI category, but you can get some percentage of a positive update. Report through claims data, or a registry.
FAQs

2. In MIPS, does what I score one year impact the next?

No. MIPS is based on fee for service. The updates are calculated annually based on your allowed fee for services billings x the conversion factor x the MIPS Composite score.

FAQs

3. Are the PQRS, MU penalties gone?

Not quite yet. Based on your work for 2015 and 2016, they are still in place for the next two years (MMS is asking new Administration to eliminate old SGR based penalties).
FAQs

4. Under MIPS, can I get partial credit for my work?

Yes. Unlike PQRS & MU, MIPS bonuses are not all or nothing. You can get 1%, 2% or up. But you can also get penalties on the same sliding scale.

FAQs

5. Are you sure this isn’t worse that the SGR??

Look at it this way. Under the SGR, in addition to the 20%+ annual cuts, the penalties under PQRS, MU etc were up to 11%. The worst you can do under MACRA in the first year is 4% cut, up to 9% in 2025. And who know what changes will happen by then.
Where can I go for Help?

MMS Game Plan

- November 2016 – Spring 2017
  - Educate and inform MMS members about the final rule

- 2017 through 2019
  - Focus on implementation through MMS Dept. on Practice Solutions and Medical Economics
  - Provide tools, in consult with AMA and National Medical Specialty groups, to help MMS members make informed choices about implementation strategy

- 2018 and beyond
  - Advocate at the national level for regulatory and legislative modifications, as appropriate
MMS Resources

www.massmed.org/MACRA

- Summary of MACRA
- Links to AMA, QIO, CMS
- Links to National Medical Specialty Groups including, specialty specific web based tools

MMS Department of Practice Solutions and Medical Economics:

Physician Practice Resource Center

pprc@massmed.org
Prepare for MACRA

- Will you likely be in MIPS or APMS?
- Are you exempt from MIPS?
  - Low volume provider?
  - Qualified participant in an advanced APM?
- Do you meet requirements for small, rural, non-patient-facing accommodations?
- Would you be reporting as a group or an individual?
Prepare for MIPS: Quality

- Are you reporting quality metrics?
- Do you plan to report through claims, EHR, clinical registry, QCDR, or group practice reporting option (GPRO) Web-interface?
- Do you plan to report as a group or an individual?
  - If a group, keep in mind all eligible clinicians (EC) in the group must report on the same measures across all 4 MIPS categories.
  - Claims reporting is only available if reporting as an individual.
  - Web-interface is only available if reporting as a group and have 25 or more EC’s.
- Check your PQRS feedback reports.

Prepare for MIPS: Improvement Activities

- Review the more than 90 plus approved Improvement Activities?
- Which Improvement Activities are you engaged in now?
- What are you interested in doing?
- Consider which 90 days in 2017 would work best for your practice’s selected Improvement Activities.
- If you participate in a PCMH or comparable specialty practice, you will receive full credit.
- Review the AMA’s Steps Forward program.
If you have an EHR, speak with your vendor about how their product supports the new payment models:
- Is your EHR certified?
- If so, is it the 2014 or 2015 edition?
- Does it support Medicare quality reporting?
- Does your vendor offer patient tracking and clinical decision support tools?
- Can your EHR connect to public health or clinical data registries?
- What Improvement Activities can your EHR help with to earn bonus points?
- Conduct a careful security risk analysis in early 2017

Although the cost component of MIPS is weighted 0% for 2019; opportunities to prepare:
- Access and review your Medicare Quality and Resource Use Reports (QRURs) to see where improvements can be made
- Plan to review feedback CMS provides for informational purposes throughout the 2017 performance period that will affect your cost score in future years
- Review your most costly patient population conditions and diagnoses and seek improvement opportunities
Prepare for APMS

- Confirm whether you are a participant in any of the advanced APMs
- If not, contact your specialty society or state medical society to find out if there are APM opportunities for your area
- Evaluate whether you are likely to meet the threshold for significant participation in an advanced APM, which would qualify you for incentive payments

Qualified Medical Homes

MIPS APMs

Physician-focused APMs TBD

Take Advantage of Educational Opportunities

www.stepsforward.org

Completion of select STEPS Forward™ modules meets eligibility criteria for Improvement Activity category credit
Offering an Iterative and Comprehensive Set of Resources

Dedicated AMA website pages
www.ama-assn.org/macra

Background/How to Prepare
Payment Model Evaluator
Steps Forward

https://qpp.cms.gov
CMS Resources

Quality Payment Program

Where do I go for help with the Quality Payment Program?

There is a new Quality Payment Program website, which will explain the new program and help clinicians easily identify the programs that work best for their patients or specialty. This will allow certified clinicians and practice managers to browse and explore the program options to fit their practice.

CMS has organizations on the ground to provide help to clinicians who are eligible for the Quality Payment Program.

We want to hear from you

Today’s final rule with commercial transparency requirements, expected to be released by the end of the year, needs your feedback to be the best rule. If you have concerns about the transparency requirements, you should weigh in now. The notice and comment period for the rule is open until February 28, 2017. Comments are encouraged and may affect the final rule and will allow comments until 60 days after the date of filing for public inspection.

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