THE UCF REGIONAL EXTENSION CENTER IS NOW

UCF REGIONAL EXTENSION CENTER

A Division of the College of Medicine

At the Forefront of Healthcare Transformation

NAVIGATING MACRA

Presented by
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AGENDA

1. What is MACRA?
2. What is MIPS?
3. How is my MIPS score calculated?
4. What is an Alternative Payment Model?

WHAT IS MACRA?

- The **M**edicare **A**ccess and **C**HIP **R**eauthorization **A**ct of 2015
- Repealed Medicare sustainable growth rate (SGR) formula that calculated payment cuts for physicians
- Established a new Quality Payment Program
  - Two payment tracks, MIPS and APM
  - "Value over volume"

TIMELINE FOR MACRA IMPLEMENTATION

2016 | 2017 | 2018 | 2019

Physician payments increase by 0.5 % each year

- 2017: Performance period for MIPS
- 2018: 3/31: Reporting deadline
  - Analysis, scoring, review
- 2019: Payment adjustments

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

WHAT IS MIPS?

- A new system of reimbursement for Medicare providers
- Consolidates Meaningful Use program, Physician Quality Reporting System, and Value-Based Modifier
- Allows providers to choose activities and measures that are relevant and meaningful to their practice or specialty
- Exempt: first-year Medicare providers, Advanced APMs, providers with low volume threshold
  - 100 patients or fewer **OR**
  - Less than or equal to $30,000 in Medicare Part B allowed charges

GROUP PARTICIPATION

MIPS allows clinicians billing under the same TIN to submit data as a group

Group members can be different specialties or at different sites

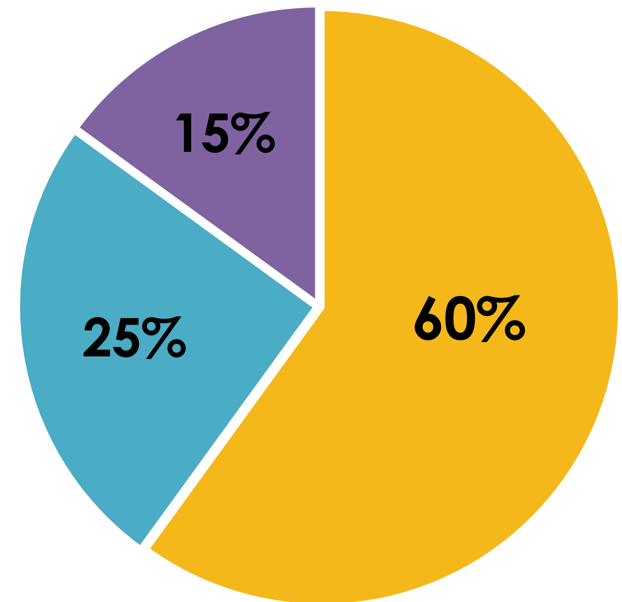
To submit data through the CMS web interface, you must register as a group by **June 30, 2017**

Group will receive one payment adjustment

WHAT IS MIPS?

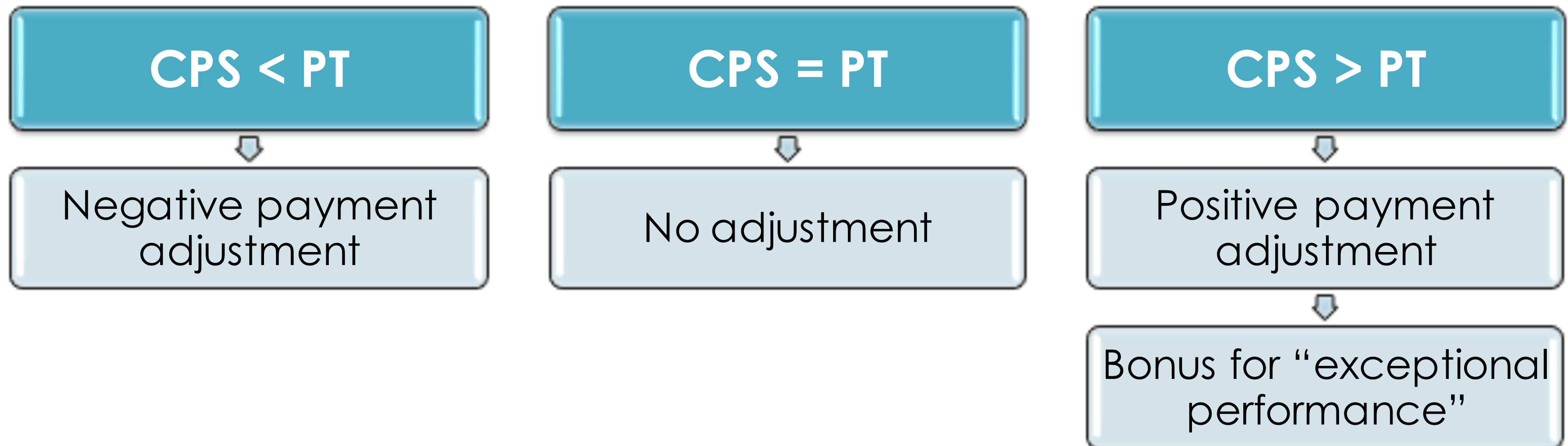
Payment to providers will be based on composite score of three factors

- Quality 60%
- Advancing Care Information 25%
- Clinical Practice Improvement 15%



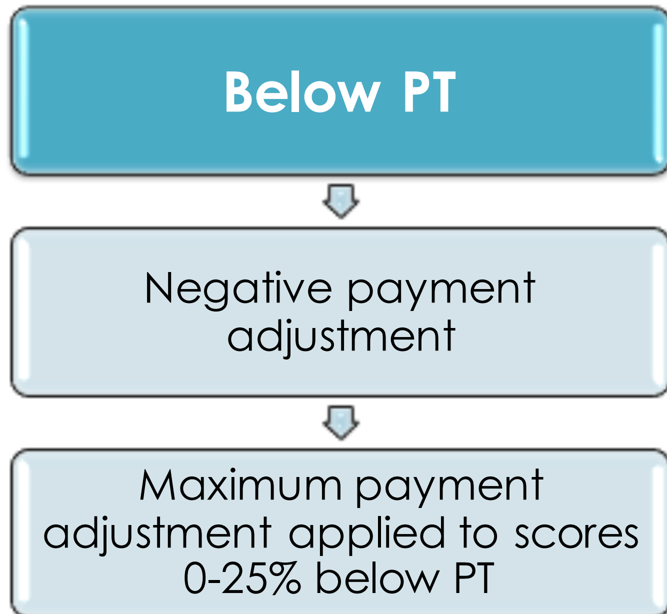
WHAT ARE THE REQUIREMENTS?

- Providers will be given points in each category. This will be the Composite Provider Score (CPS)
- The CPS will be compared to the MIPS Performance Threshold Score (PT).



THE FINANCIAL IMPACT

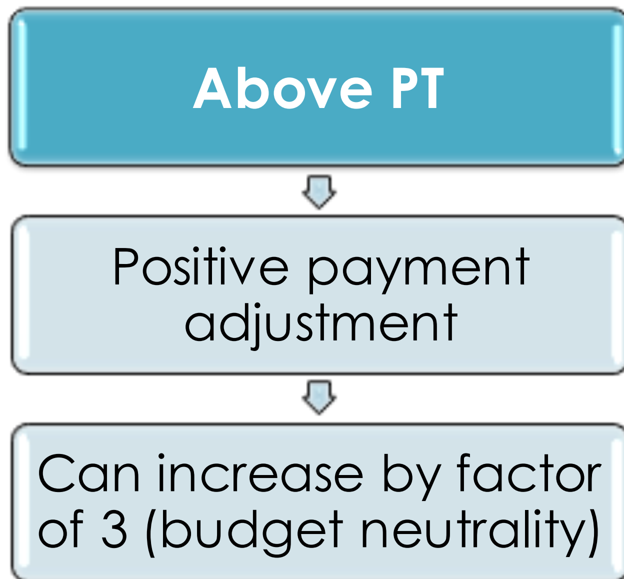
For 2017, eligible clinicians who report NO data will receive a -4% adjustment



Measurement Year	Payment Year	Max. Adjustment to base rate
2017	2019	-4%
2018	2020	-5%
2019	2021	-7%
2020	2022	-9%

THE FINANCIAL IMPACT

For 2017, eligible clinicians who submit more than the minimum data requirement will qualify for a positive adjustment



Measurement Year	Payment Year	Max. Adjustment to base rate	Maximum Increase
2017	2019	4%	12%
2018	2020	5%	15%
2019	2021	7%	21%
2020	2022	9%	27%

HOW DO I PARTICIPATE?

- "If MIPS eligible clinicians choose to not report even one measure or activity, **they will receive the full negative 4 percent adjustment**."
- Report one quality measure, participate in one activity, **OR** report the 5 required measures for advancing care information: avoids negative adjustment
- Submit more than the minimum required but not participate fully: avoids negative adjustment, qualifies for positive payment adjustment

HOW DO I PARTICIPATE?

Full participation for at least a 90-day period—eligible for positive payment adjustment and possible exceptional performance bonus

Full participation:

- 6 quality measures **or** one specialty-specific measure set, including at least 1 outcome measure
- 40 points of Clinical Improvement Activities
- 5 required measures for Advancing Care Information

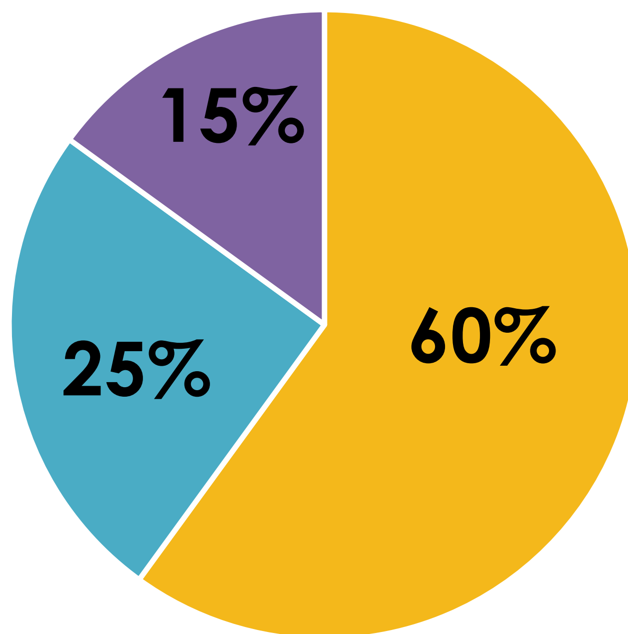
HOW DO I PARTICIPATE?

- Positive adjustments are based on the performance data submitted, not the amount of information or how long you participate
- Bonus payment is also based on score, not degree of participation
- Participating for a full year is the BEST way to prepare for the future of the program

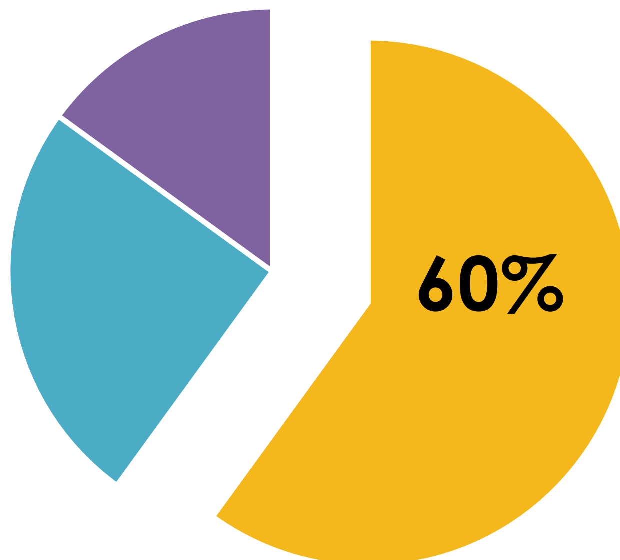
SCORING FOR 2017

0 points	-4% adjustment
3 points	No adjustment
4-69 points	Positive adjustment
70+ points	Positive adjustment **AND** bonus of at least 0.5%

PERFORMANCE CATEGORIES FOR MIPS



CATEGORY 1: QUALITY



CATEGORY 1: QUALITY

- Replaces the current PQRS program
- Separate PQRS payments/penalties will sunset in 2018
- Performance is compared to national peer benchmarks
- Select six measures from the available list **or** a block of measures that fits your specialty

CHANGES FROM PQRS

PQRS	MIPS Quality Category
Report all required measures to avoid payment adjustment	Choose the number of measures to report on
Report 9 measures across 3 domains	Report on 6 measures, including 1 outcome measure
CAHPS required for groups with 100 or more EPs	Groups may choose CAHPS as a quality measure
Submit score separately from other payment programs	Options for submitting at the same time as other categories

EXTRA CREDIT!

- Reporting additional outcome measure(s)
- Reporting other high priority measures
  - Appropriate use
  - Patient safety
  - Efficiency
  - Care coordination
- Patient experience
- End-to-end reporting through CEHRT

SUBMITTING MEASURES

- For 2017, submitting one measure meets the MIPS performance threshold
- Additional points are awarded for submitting more measures, high performance
- Groups using the CMS Web Interface must report on 15 measures, for the full year
- Providers in APMs will report through their APMs

SCORING

Your Points	Total Possible Points
Points given based on performance + Bonus points	Number of required measures x 10

Your points ÷ Total possible points = Quality score

SCORING EXAMPLE

- You submit data on 6 measures
- You earn **42** points
- You earn **1** bonus point for choosing a patient safety measure
- You earn **2** points for submitting 2 measures through your EHR

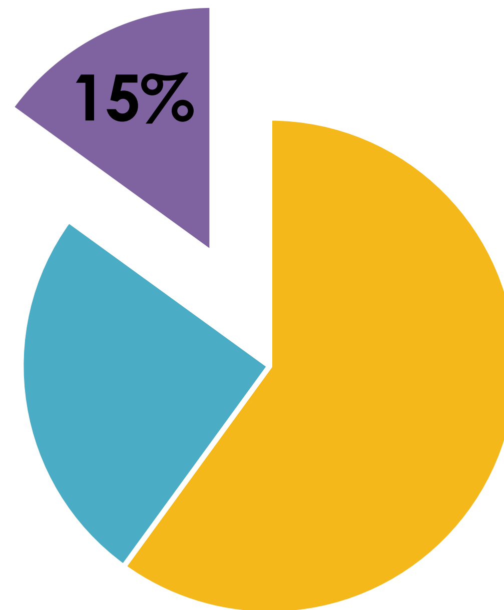
Your Points = 45

6 scored measures
x10

Possible points = 60

$$45 \div 60 = 0.75$$

CATEGORY 2: CLINICAL PRACTICE IMPROVEMENT



CATEGORY 2: CLINICAL PRACTICE IMPROVEMENT

- New category
- Select at least one activity from list of 93 activities
- High weight activities = 20 points each
  Medium weight activities = 10 points each
- [Available points in 2017: 40]

SCORING

(Total number of points earned ÷ 40) = score

Example: (20 ÷ 40) = 0.50

Solo providers, small practices, rural clinics, geographic health professional shortage areas: complete 1 high weight **or** 2 medium weight activities to earn all 40 points.

APM SCORING FOR 2017

- Certified patient centered medical homes, comparable specialty practices, designated Medical Home Model = automatic **40 points**
- MIPS APMs= automatic **40** points
- Any other APM = automatic **20 points**. May earn additional points by completing other activities

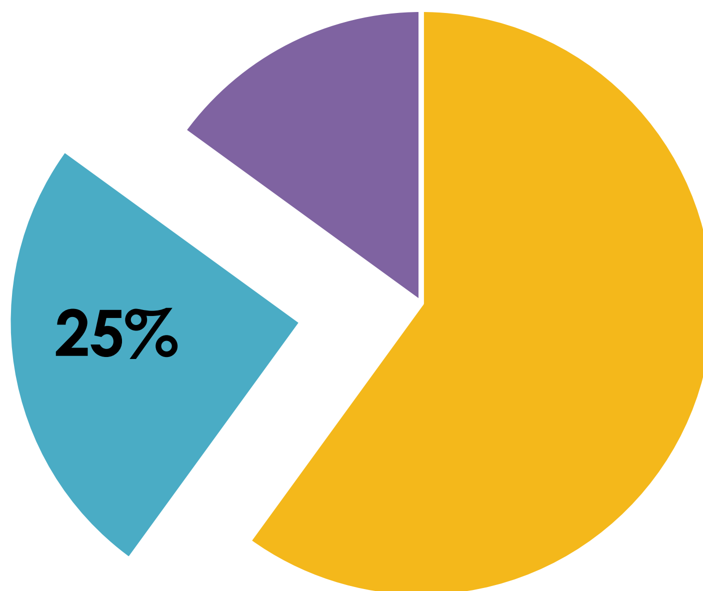
WHAT IS A “MIPS APM”?

MIPS-eligible clinician who is part of an Alternative Payment Model (APM) but is not a Qualifying Provider (QP)

MIPS APMs for 2017

- Shared Savings Program Tracks 1-3
- Next Generation ACO
- Comprehensive ESRD Care, all arrangements
- Oncology Care Model, all arrangements
- Comprehensive Primary Care Plus (CPC+)

CATEGORY 3: ADVANCING CARE INFORMATION



CATEGORY 3: ADVANCING CLINICAL INFORMATION

- **Restructuring** of Meaningful Use
- Separate meaningful use payments and reporting for Medicare will sunset in 2018
- Optional participants: NP, PA, CRNA, CNS, hospital-based eligible clinicians
- Hardship exemption for this category *only*

MEDICARE/MEDICAID PROVIDERS

Do I also see Medicaid Patients?

Yes

No

Do I meet the Medicaid volume requirement?

No

Do I meet the Medicare low volume threshold?

No

Yes

Yes

Report to Medicaid

No reporting required

Report to MIPS

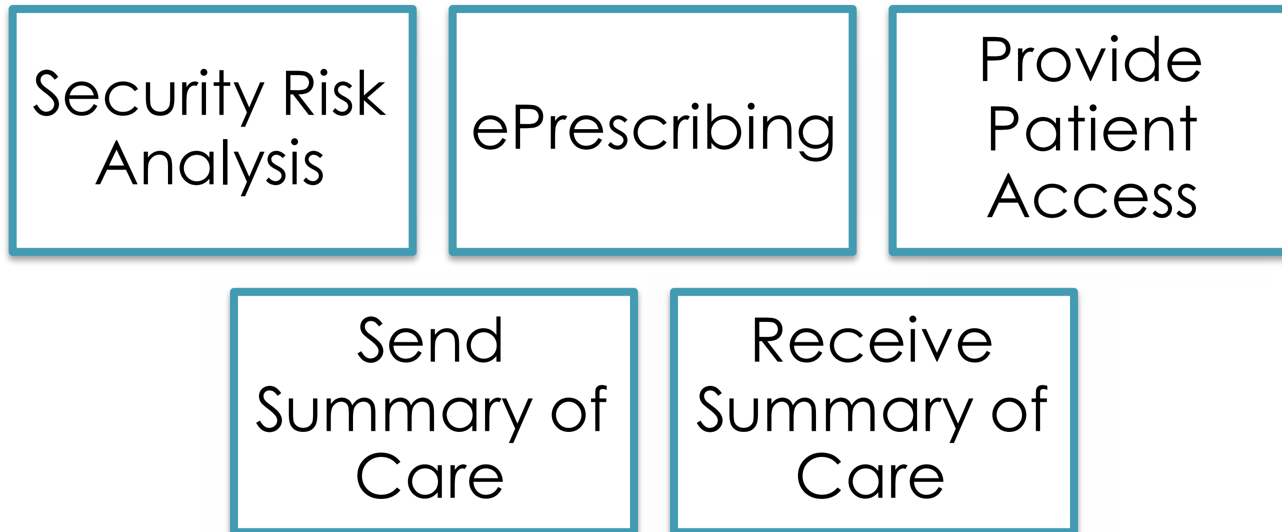
EHR INCENTIVE PROGRAM VS. ADVANCING CARE INFORMATION

Meaningful Use	Advancing Care Information
Every objective reported and equally weighted	Choose which categories to emphasize
All clinicians have to meet the same thresholds, regardless of practice's needs or experience	Allows for diverse reporting that matches clinician's practice and experience
Emphasized process	Emphasizes patient engagement and interoperability
All or nothing scoring approach	Flexible scoring
No exemptions from reporting	Providers who are already exempt from MIPS

SCORING FOR CATEGORY 3

Base Score = 50%

- Provider will answer yes/no or provide the numerator/denominator for each objective



OBJECTIVES AND MEASURES

Required Measures

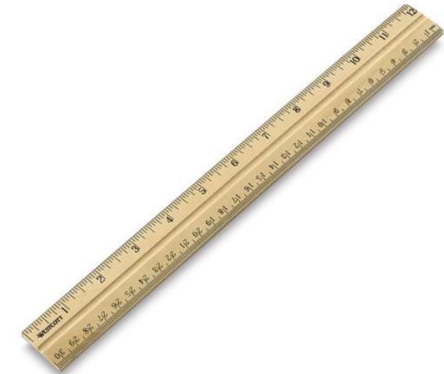
1. Conduct a security risk analysis
2. Query drug formulary and transmit prescription electronically
3. Provide patients timely access to their information online
4. Send summary of care electronically
5. Receive summary of care electronically

SCORING FOR CATEGORY 3

Performance score

- 90 % available
- Overall Category 3 score cannot exceed 100 points

Patient Electronic Access	Coordination of Care Through Patient Engagement
Health Information Exchange	Public Health & Clinical Data Reporting



PERFORMANCE SCORE MEASURES

Objective	Measure
Patient Electronic Access	Provide Patient Access* Patient Specific Education
Coordination of Care Through Patient Engagement	View, Download, Transmit Secure Messaging Patient-Generated Health Data
Health Information Exchange	Send a Summary of Care* Request/Accept Summary of Care* Clinical Information Reconciliation
Public Health (optional)	Active Engagement with an Immunization Registry

TRANSITION OBJECTIVES AND MEASURES

Providers using EMRs with 2014 certification

- Report numerator/denominator from Health Information Exchange in place of Send Summary of Care
- May use numerator/denominator from Medication Reconciliation in place of Clinical Information Reconciliation
- Must upgrade to 2015 certification by 2018

PUBLIC HEALTH & CLINICAL DATA REGISTRY REPORTING

BONUS POINTS!

- Electronic case reporting
- Public health registry
- Clinical data registry
- Syndromic surveillance
- Clinical Improvement Activities that use CEHRT

OVERALL SCORING FOR CATEGORY 3

(10 points x base objectives achieved) + Decile for performance measures = Total Category 3 score

Example:

Achieved all 5 base measures	= 10 x 5 =	50
Performance objective 1	= 60 % =	6
Performance objective 2	= 30 % =	3
Performance objective 3	= 80 % =	+ 8
		67

CALCULATING YOUR FINAL SCORE

CALCULATING YOUR FINAL MIPS SCORE

(Quality score x 60%) + (Clinical Improvement score x 15%) + (Advancing Care score x 25%) X 100 = Your MIPS Score

Remember!

0 points = negative adjustment

3 points = no adjustment

4-69 points = positive adjustment

70+ points = positive adjustment AND bonus of at least 0.5%

EXAMPLE

Achieved 75% in Quality

Completed 50% in Clinical Improvement

Earned 67% in Advancing Care Information

$$(0.75 \times 0.60) + (0.50 \times 0.15) + (0.67 \times 0.25) =$$

$$0.45 + 0.075 + 0.1675 = 0.6925$$

$$0.6925 \times 100 = 69 \text{ points}$$

MIPS: A SUMMARY

- "Quality, Not Quantity"
- Flexible scoring
- 2017 Performance period = at least 90 days
- Scores in 3 categories
  - Quality
  - Clinical Practice Improvement
  - Advancing Clinical Information

ALTERNATIVE PAYMENT MODELS

ALTERNATIVE PAYMENT MODELS

- What is an Alternative Payment Model?
- Medical Home Model and Advanced APMS in 2017
- Risk and Capitation
- Partial Qualifying APM Participants and Qualifying Provider determinations
- Benefits of APM participation and Payment under an APM
- Timeline

WHAT IS AN ALTERNATIVE PAYMENT MODEL?

- Payment Arrangement
- Developed in partnership with the clinician community
- Provides added incentives to clinicians to provide high-quality and cost-efficient care.
- Can focus on a specific clinical condition, a care episode, or a population.

WHAT IS AN ALTERNATIVE PAYMENT MODEL?

MACRA Definition

- Innovative payment model expanded under CMMI
- A Medicare Shared Savings Program Accountable Care Organization (ACO)
- Medicare Health Care Quality Demonstration Program
- Medicare Acute Care Episode Demonstration Program
- Another demonstration program required by federal law

WHAT IS AN ADVANCED ALTERNATIVE PAYMENT MODEL?

Alternative Payment Model ≠ Advanced APM

Advanced APMs

- Require participants to use certified EHR technology
- Base payments for services on quality measures comparable to MIPS
- Be a Medical Home Model expanded under CMMI
- Bear more than nominal financial risk

WHAT IS AN ADVANCED ALTERNATIVE PAYMENT MODEL?

Advanced APMs

- Practice receives direct payment from the APM Entity
- Reduction in payment rates to the APM Entity or eligible clinicians
- Withholding payment to the APM Entity or eligible clinicians

ADVANCED APMS IN 2017

- Shared Savings Program (Tracks 2 and 3)
- Next Generation ACO Model
- Comprehensive ESRD Care (CEC)
- Comprehensive Primary Care Plus (CPC+)
- Oncology Care Model (OCM)
- Vermont Medicare ACO Initiative

ADVANCED APMS IN DEVELOPMENT

- Advancing Care Coordination through EPMs Track 1 and 2
- Cardiac Rehabilitation Incentive
- Comprehensive Care for Joint Replacement
- Medicare ACO Track 1+
- Medicare Diabetes Prevention Program

MINIMUM ELEMENTS FOR A MEDICAID MEDICAL HOME MODEL

Primary care practices and multispecialty practices that include PCPs and offering primary care services.

Empanelment of each patient to primary clinician and at least four of the following:

- Planned coordination of chronic and preventive care
- Patient access and continuity of care
- Risk-stratified care management
- Coordination of care
- Patient and caregiver engagement
- Shared decision-making
- Payment arrangements in addition to/substituting fee-for-service payments

WHAT IS AN ADVANCED ALTERNATIVE PAYMENT MODEL?

	Nominal Risk Criteria	What Does This Mean?
1	**Minimum Loss Rate:** A threshold to trigger losses no greater than 4%	The APM contract must require the APM entity to assume responsibility for losses once spending reaches 4% or less above expected expenditures
2	**Marginal Risk:** Loss sharing of at least 30%	APM Entities must share with the payer in at least 30% of the losses in excess of the expected expenditures
3	**Stop Loss:** Maximum possible loss of at least 4%	APM entity's maximum potential losses can't be capped lower than 4% of the total expected expenditures

CAPITATION

Full capitation risk arrangements meet the Advanced APM financial risk criterion.

Medicare Advantage and other private plans paid to act as insurers on the Medicare program's behalf are not Advanced APMs.

Involve full risk for population of beneficiaries covered by arrangement

The APM Entity bears the **full** downside and upside risk in this regard.

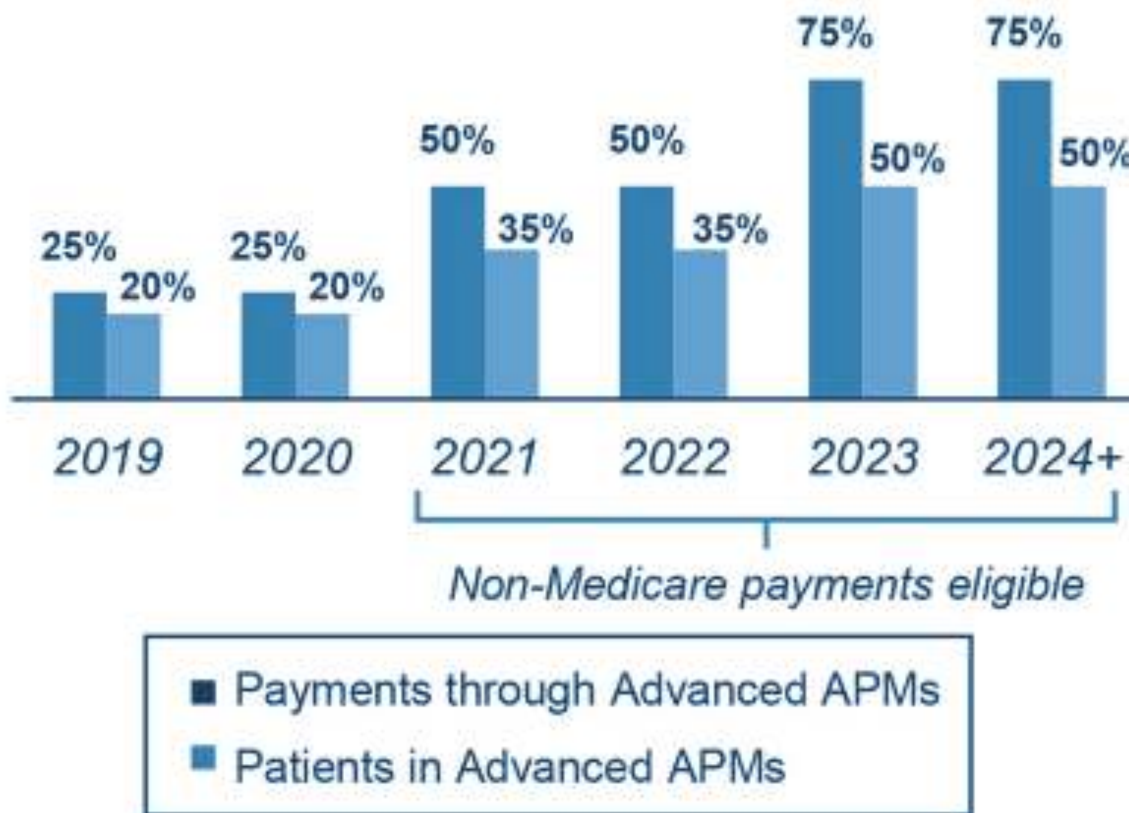
KEY DATES FOR APM SCORING

To be considered part of an APM Entity an EP must be on an APM participation list on at least one of these dates during the performance period

PARTIAL QUALIFYING APM PARTICIPANTS

- An Eligible Provider who **does not** meet the established thresholds, but does meet slightly reduced thresholds
- These participants do not receive the 5% APM incentive payment
- They can participate in MIPS, but are **not penalized** if they do not participate in MIPS

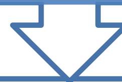
PARTIAL QUALIFYING APM PARTICIPANTS



QUALIFYING PROVIDER DETERMINATIONS

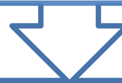
Alternative Payment Model (APM)

APM meets Advanced Payment Model Criteria



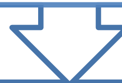
Advanced APM

APM Entity participates in advanced APM



Advanced APM Entity

Eligible Clinicians in Advanced APM Entity collectively meet QP threshold of participation



Qualifying APM Participant (QP)

BENEFITS OF APM PARTICIPATION

- Qualifying Participants are excluded from the MIPS
- Partial Qualifying Participants can opt out of MIPS participation
- Alternative Payment Models reduce the reporting burden for MIPS
- Participation in an APM increases likelihood of MIPS success

PAYMENT UNDER AN APM

If an organization is eligible, chooses to participate in a qualifying APM, and meets specified payment thresholds:

- They will receive a 5% lump-sum bonus on Medicare payments for 2019 through 2024.
- Beginning in 2026, they will qualify for a 0.75% increase in payments each year

WHEN WILL THIS HAPPEN?

2017 - 2018

All clinicians will report MIPS data

Providers in APMs will get points for clinical practice improvement activities (at least ½)

2019- 2024

Advanced APMs receive a lump sum payment equal to 5% of their prior year's payments for Part B covered professional services.

2021+

EPs may qualify through a combination of participation in Advanced APMs and APMs with other payers.

WHAT CAN YOU DO NOW TO PREPARE FOR MACRA?

1. If you're in an APM, check with your administrator to see if you're meeting the qualifications under MACRA.
2. If you will be in MIPS, check if you meet the low volume threshold.
3. Assess your current performance with PQRS, VM, MU
4. Check with your EHR vendor. How are they preparing?
5. Review the list of proposed clinical improvement activities

BE PREPARED!

Submitting ZERO data = negative payment adjustment

Submitting SOME data= avoid negative adjustment
possible positive adjustment

CMS believes that providers who take advantage of this "test run" year will be better prepared for 2018, so you can map your route to success!

HOW HEALTHARCH CAN HELP YOU

MACRA Education and Assessment

PCMH Recognition & Transformation

Revenue Cycle Management

Security Risk Assessment

HIPAA Training

QUESTIONS?

Thank you for attending!

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