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MACRA: What We Know, Don't Know, and How to Prepare

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Key Topics

- Overview
  - Quality Payment Program & HHS Goal
  - Understanding MACRA
- Merit Based Incentive Program (MIPS) & Advanced Alternative Payment Model
- Reporting & Submitting
- Industry Feedback & Politics
- Preparing for Value Based Reimbursement

OVERVIEW

Program, Goals, Stakeholders, and More!

MACRA – A Broader Push Towards Value & Quality

In January 2015, the Department of Health & Human Services announced **new goals** for **value-based payments** and **APMs in Medicare**

Medicare Fee-for-Service

GOAL 1:

Medicare Payments are tied to Quality or Value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018

30%

GOAL 2:

Medicare fee-for-service payments are tied to quality of value (categories 2-4) by the end of 2016, and 90% by the end of 2018

85%

STAKEHOLDERS

CONSUMERS | BUSINESSES | PAYERS | PROVIDERS | STATE PARTNERS

Set **internal goals** for HHS

Invite **private sector payers** to match or exceed HHS goals

Medicare Payment Prior to MACRA

- Fee-for-service (FFS) payment system, where clinicians are paid based on volume of services, not value.

- The Sustainable Growth Rate (SGR)
  - Each Year, Congress passed temporary "doc fixes" to avert cuts (no fix in 2015 would have meant a 21% cut in Medicare payments to clinicians)

- MACRA replaces the SGR with a more predictable payment method that incentivizes value

Source: CMS's "The Merit-Based Incentive Payment System (MIPS)" Webinar

Medicare Reporting Prior to MACRA

- Currently, there are multiple quality and value reporting programs for Medicare clinicians:

Physician Quality Reporting Program (PQRS)	Value-Based Payment Modifier (VM)	Medicare Electronic Health Records (EHR) Incentive Program

Source: CMS's "The Merit-Based Incentive Payment System (MIPS)" Webinar

Quality Payment Program

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- **Provides incentive payments** for participation in **Advanced Alternative Payment Models (APMs)**

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

- First step to a fresh start
- A better, smarter Medicare for healthier people
- Pay for what works to create a Medicare that is enduring
- Health information needs to be open, flexible, and user-centric

Source: CMS's "The Merit-Based Incentive Payment System (MIPS)" Webinar

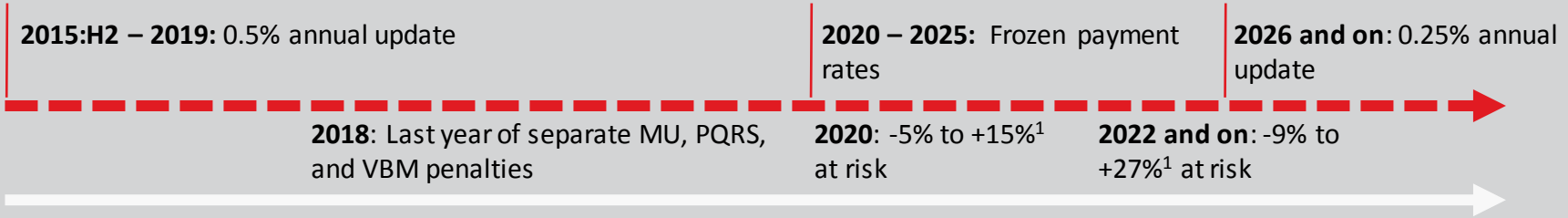
MIPS & ADVANCED APM

Understanding the Differences

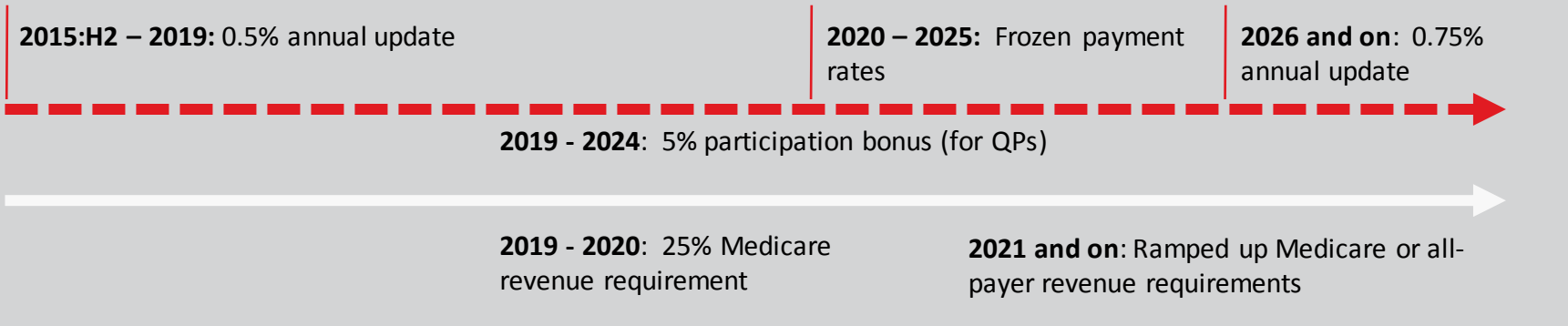
MACRA Creates 2 Tracks for Providers

Providers Must Choose Either MIPS or Alternative Payment Model Track

Track 1 - Merit-Based Incentive Payment System



Track 2 - Advanced Alternative Payment Models



Who Will Participate in MIPS?

- Affected clinicians are called "MIPS eligible clinicians" and will participate in MIPS. The types of Medicare Part B eligible clinicians affected by MIPS may expand in future years.

Years 1 & 2

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

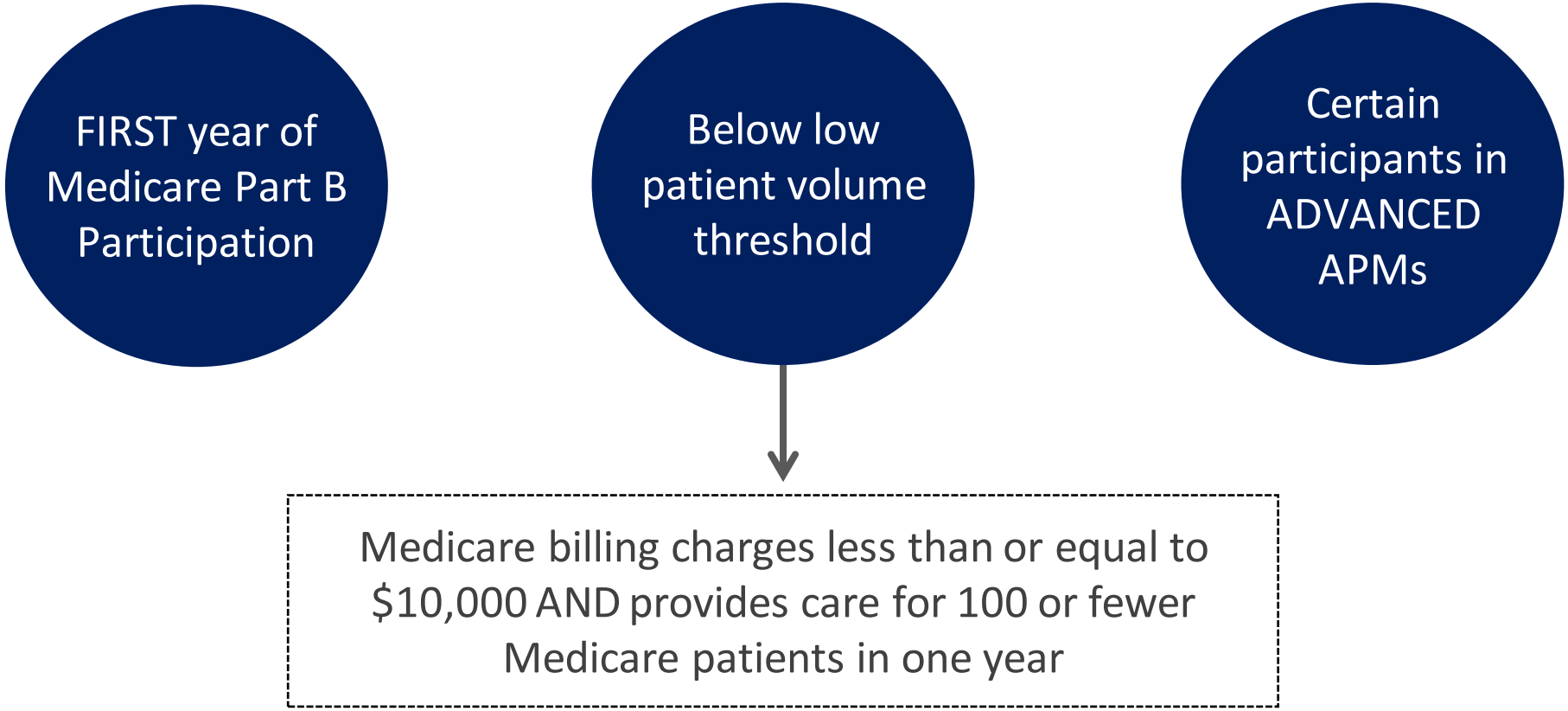
Years 3+

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

Source: CMS's "The Merit-Based Incentive Payment System (MIPS)" Webinar

Who will NOT Participate in MIPS?

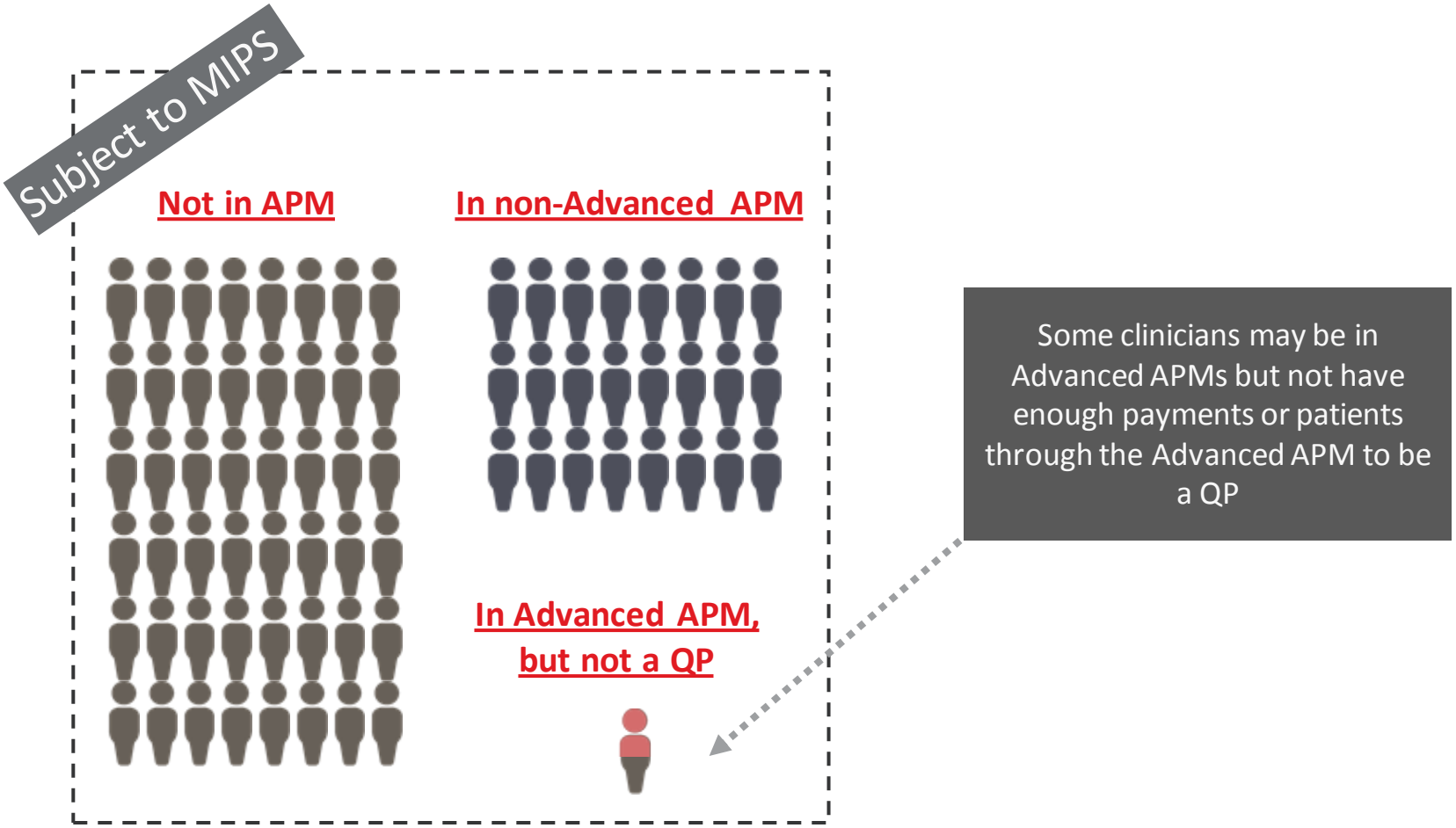
There are 3 groups of clinicians who will NOT be subject to MIPS:



Note: MIPS does not apply to hospitals or facilities

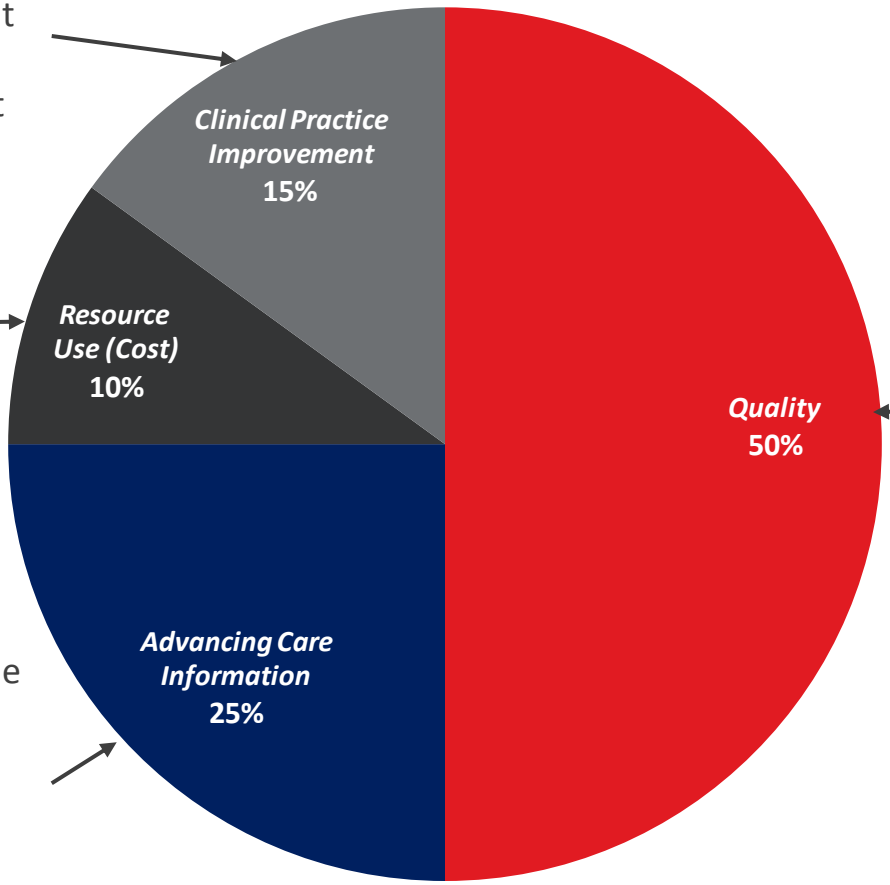
Source: CMS's "The Merit-Based Incentive Payment System (MIPS)" Webinar

Most Clinicians Will be Subject to MIPS



Year 1 of the MIPS Program

- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary Engagement



- Value-Based Modifier measures
- Risk-adjusted outcome measures

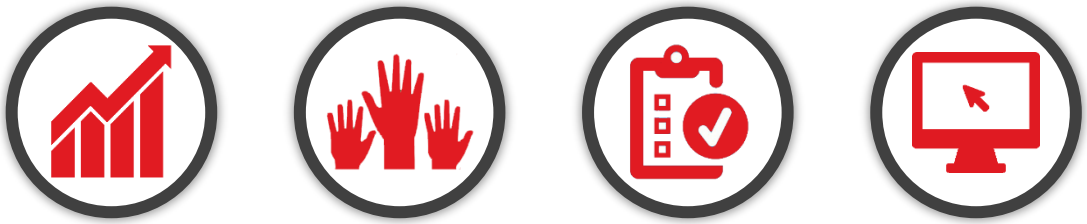
- PQRS measures
- eCQMs
- QCDR measures
- Risk-adjusted outcome measures

- Adjusted Meaningful Use requirements
- ACI weight may be adjusted down to 15 percent if 75% or more EPs are meaningful users

Calculating the CPS for MIPS

PROPOSED RULE — MIPS: Calculating the Composite Performance Score (CPS) for MIPS

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



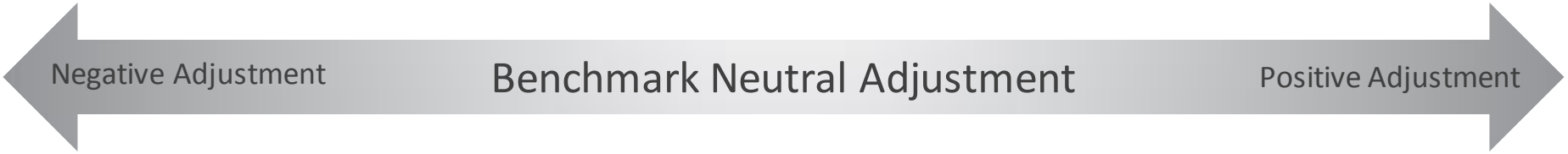
QUALITY | RESOURCE USE | CLINICAL PRACTICE IMPROVEMENT | ADVANCING CARE INFORMATION

MIPS Composite Performance Score (CPS)

The CPS will be compared to the MIPS performance threshold to determine the adjustment percentage the eligible clinician will receive.

Source: CMS's "The Merit-Based Incentive Payment System (MIPS)" Webinar

MIPS Payment Adjustments



	2015	2016	2017	2018	2019	2020	2021	2022+
PQRS+VM+ EHR Incentive Penalties (combined)	-4.5%	-6.0%	-9.0%	-10% or more	-11% or more	-11% or more	-11% or more	-11% or more
MIPS Bonus/Penalty (max)	-4.5%	-6.0%	-9.0%	-10% or more	+4%* -4%	+5%* -5%	+7%* -7%	+9%* -9%

* May be increased by up to 3 times to incentivize performance $500 mil funding for bonuses allocated through 2024

MIPS is a Zero-Sum Game

- MIPS is intended to be a Budget-Neutral Program
  - The rule discusses how under MACRA's requirements, MIPS would distribute payment adjustments to between approximately 687,000 and 746,000 eligible clinicians in 2019
  - Payment adjustments would be based on MIPS eligible clinicians' performance on specified measures and activities within the four performance categories
  - CMS' initial estimate is that MIPS payment adjustments would be approximately equally distributed between negative adjustments ($833 million) and positive adjustments ($833 million) to MIPS eligible clinicians, to ensure budget neutrality

- For APMs, CMS estimates that between approximately 30,658 and 90,000 eligible clinicians would become qualifying providers through participation in Advanced APMs, and are estimated to receive between $146 million and $429 million in APM Incentive Payments for CY 2019

Alternative Payment Model Track

- There are two types of Advanced APMs through which clinicians can qualify for incentive payments under MACRA: Advanced APMs and Other Payer Advanced APMs

- Requirements for Advanced APMs:
  - Require participants to use certified EHR technology
  - Provide payment for covered professional services based on quality measures similar to those used in the quality performance category of MIPS
  - Bear more than a nominal amount of risk for monetary losses or be a medical home model that CMS has expanded

- The first reporting period for Advanced APMs begins by January 1, 2017

- Other Payer Advanced APMs have the same requirements, but can also be a Medicaid Medical Home Model
  - Clinicians can qualify for APM incentives through Other Payer Advanced APMs beginning in 2021, based on performance in 2019

Source HIMSS 2016

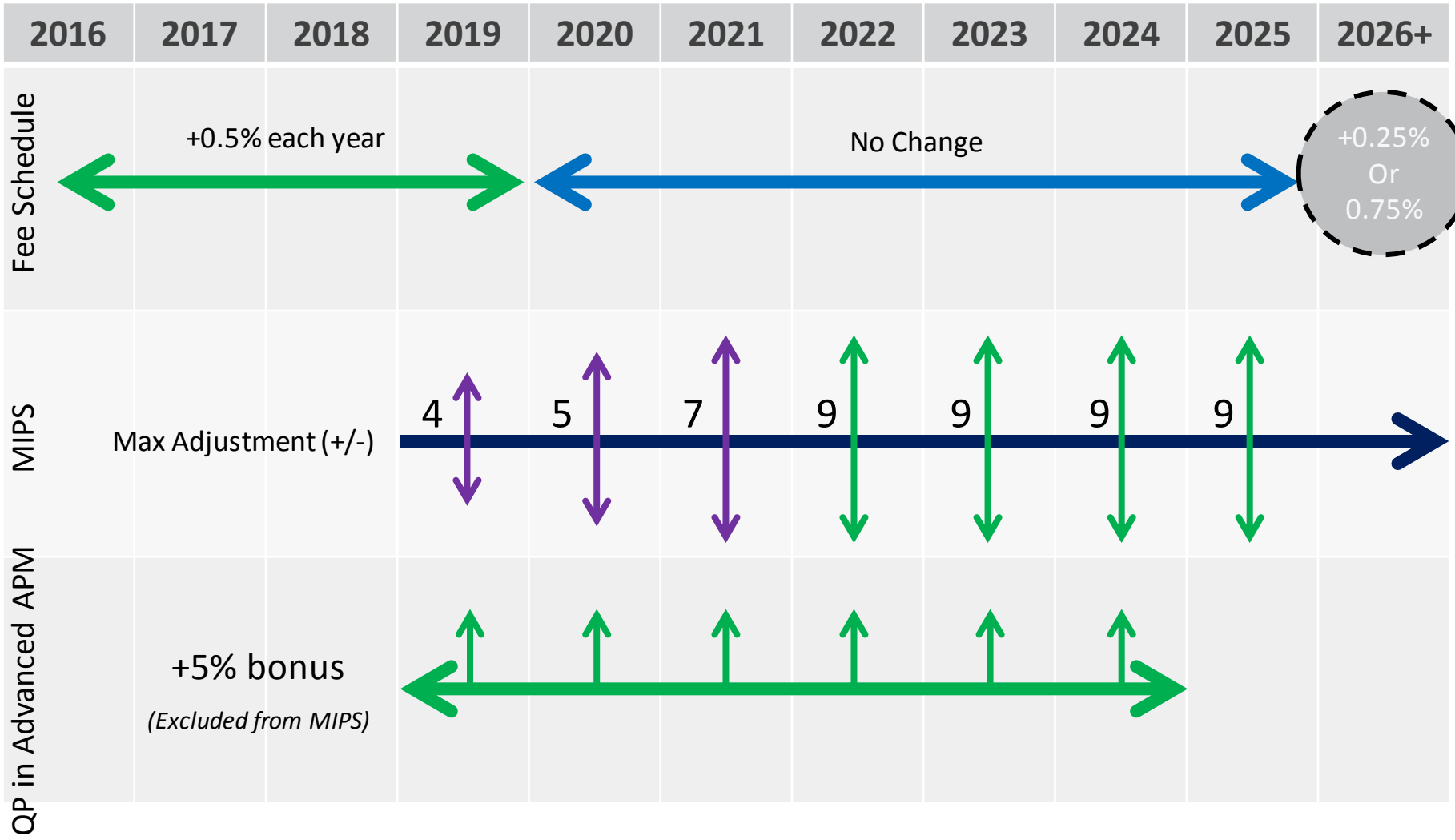
Advanced APMs for 2017/2019

- Advanced APMs through which clinicians could qualify for incentive payments in 2019 include:
  - Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) Large Dialysis Organization (LDO) arrangement
  - Comprehensive Care Plus (CPC+)
  - Medicare Shared Savings Program (MSSP) Track 2
  - MSSP Track 3
  - Next Generation Accountable Care Organization (ACO) Model
  - Oncology Care Model (OCM) two-sided risk arrangement (available 2018)

NOTE: Bundled Payment for Care Improvement initiative and MSSP Track 1 are not included

Source HIMSS 2016

Putting it all together:



SUBMITTING FOR MIPS

Reporting & Submission Breakdown

MIPS Data Submission Options

	INDIVIDUAL REPORTING	GROUP REPORTING
 QUALITY	Attestation QCDR Qualified Registry EHR Vendor	Attestation QCDR Qualified Registry EHR Vendor CMS Web Interface (Group of 25+)
 RESOURCE USE	Administrative Claims (No submission required)	Administrative Claims (No submission required)
 ADVANCING CARE INFORMATION	Attestation QCDR Qualified Registry EHR Vendor	Attestation QCDR Qualified Registry EHR Vendor CMS Web Interface (Group of 25+)
 CLINICAL PRACTICE IMPROVEMENT	Attestation QCDR Qualified Registry EHR Vendor Administrative Claims (No submission required)	Attestation QCDR Qualified Registry EHR Vendor CMS Web Interface (Group of 25+)

Source: CMS's "The Merit-Based Incentive Payment System (MIPS)" Webinar

Changes to Meaningful Use in MACRA NPRM

Meaningful Use	Advancing Care Information
Must report on all objective and measure requirements	New proposal streamlines measures and emphasizes interoperability, information exchange, and security measures. Clinical Decision Support and Computerized Provider Order Entry are no longer required.
One-size-fits-all—every measure reported and weighed equally	Customizable—Physicians or clinicians can choose which best measures fit their practice
All-or-nothing EHR measurement and quality reporting	Flexible—multiple paths to success
Misaligned with other Medicare reporting programs	Aligned with other Medicare reporting programs. No need to report quality measures as part of this category

Source HIMSS 2016

Additional MACRA NPRM Requirements for MU Providers

- CMS is adding the surveillance of certified EHR technology to the attestation requirements under MU, the ACI performance category score under MIPS, and reporting under the APM track
  - CMS is proposing to require EPs, EHs, and CAHs to attest (as part of their demonstration of MU) that they have cooperated with the surveillance of certified EHR technology under the ONC Health IT Certification Program

- CMS is also requiring providers to attest to facilitating health information exchange and not blocking information
  - CMS is proposing that MU EPs, EHs, CAHs, and ACI as well as some APM participants demonstrate their adherence to model interoperability and exchange practices

Source HIMSS 2016

Summarizing MACRA

- Synopsis
  - Repeals the sustainable growth rate (SGR) formula
  - Changes the way that Medicare rewards clinicians for value over volume
  - Streamlines multiple quality reporting programs with a new single Merit-Based Incentive Payment System (MIPS) program that makes it easier for physicians to earn rewards for providing high-quality, high-value health care
  - Provides bonus payments for participation in eligible alternative payment models (APMs)

- Goals
  - Offer multiple pathways with varying levels of risk and reward for providers to tie more of their payments to value.
  - Over time, expand the opportunities for a broad range of providers to participate in APMs.
  - Minimize additional reporting burdens for APM participants.
  - Promote understanding of each physician's or practitioner's status with respect to MIPS and/or APMs.
  - Support multi-payer initiatives and the development of APMs in Medicaid, Medicare Advantage, and other payer arrangements.
  - Underlying theme: Health IT critical to quality reporting and payment

Source HIMSS 2016

INDUSTRY FEEDBACK & POLITICS

What the Experts are Saying

Feedback from providers to K.DeSalvo & A.Slavitt

Consistent themes:

- Providers hampered by lack of interoperability, poor patient tracking
  - Let outcomes drive the system (pull v push)
  - Improvements essential for precision medicine
  - LTPAC and Behavioral Health interoperability incentives forthcoming

- Regulations slow down clinicians, distract
  - Decrease documentation going forward

- Technology still cumbersome
  - Focus on flexibility and control
  - Flexible vendor incentives should promote user focus
  - Move to APM technology based chassis, not FFS

Hot Off the Press – Participation Options from CMS

First Option: Test the Quality Payment Program

Providers must submit some QPP data beginning Jan 1 2017 to avoid a negative payment adjustment. This option is designed to ensure that their systems are working and they are prepared for broader participation in the future.

Second Option: Participate for part of the calendar year

Providers can choose to submit QPP information for a reduced number of days in 2017 which allows their performance period to begin after Jan 1 2017. Providers could qualify for a small positive payment adjustment

Third Option: Participate for the full calendar year

Providers can choose to submit QPP information for a full calendar year. Providers could qualify for a modest positive payment adjustment

Fourth Option: Participate in an Advanced Alternative Payment Model

Providers qualifying to meet the QPP thresholds and choosing this option, would qualify for a 5% incentive payment in 2019

http://www.himss.org/news/cms-previews-quality-payment-program-changes-fy-2017-performance-year-allows-clinicians-pick-their

The Politics of MACRA & What is Ahead

- In Washington, budget reigns supreme
- MACRA has bipartisan support; will be the physician payment paradigm going forward
- Congress interested in long-term solutions to care delivery, patient access and safety, and cost
- Congress does NOT want MACRA to "just be" the new SGR – wants quality reporting & interop
- Many details still to be worked out; shifting to value-based care important to Republican or Democratic President

Source HIMSS 2016

PREPARING FOR VBP

What's to Come in Value-Based Purchasing

Considerations in Preparing for VBR Models

- Build a team-based approach to care
  - Manage across the care continuum
  - Promote Patient Family Engagement
  - Ensure access for patients
- Dedication and Understanding of Data/Enterprise Data Warehouse (EDW)
  - Preparing for Population Health Care Delivery
    - Understand your organization; who it serves and how to serve that population
- Data is a key to managing VBR models
  - How its tracked, measured, and analyzed. Also, how it relates to financial results and ROI
- Care Management & Financial Teams Must Work Together
  - Care Management must understands outcomes related to payment
  - Financial teams must understand the best practices for targeted outcomes
  - Understand the cost of care
  - Eliminate the data divisions between Financial and Clinical…they are NOT separate systems
- Metrics and Dashboards
  - Bottom Up vs Top Down
  - Metrics that do not punish, but encourage outcomes and develop successful protocols
  - Conduct coding and documentation review
- Know your organizational readiness and gaps to take on VBR and risk models.

References

CMS Quality Payment Program

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MIPS-NPRM-Slides.pdf

HIMSS MACRA Resource Center

http://www.himss.org/MACRA-resource-center

THANK YOU !!

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