MACRA

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MACRA: DISRUPTIVE BY DESIGN

Federal payment policies are accelerating the shift from volume to value which will require providers to pursue transformational change. MACRA is designed to drive down medical costs by changing how the payment and care delivery system for clinicians, providers and health plan operates.

MACRA radically changes Medicare reimbursement and for the first time evaluates clinicians' performance **at an individual level**

MACRA offers significant financial incentives for health care professionals to participate in risk-bearing, coordinated care models and to **move away from the traditional fee for service system**

MACRA is poised to drive increased participation in **risk-bearing coordinated care models across all payers, not just Medicare**

CMS

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DON'T WAIT ON CHANGES

- Some think changes in the ACA will stop MACRA…..
- MACRA is a bipartisan act, it is not part of the ACA.
- MU came from the American Recovery and Reinvestment Act of 2009
- PQRS came from the Tax Relief and Health Act of 2006, penalties were imposed by ACA
- The Value Based Modifier is part of the ACA

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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)

- Established in 1997 to control the cost of Medicare payments to physicians

IF Overall physician costs > Target Medicare expenditures → Physician payments cut across the board

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)

WHAT DOES THE QUALITY PAYMENT PROGRAM DO?

Creates Medicare payment methods that promote quality over volume by:

Repealing SGR formula

Creating two tracks:

- MIPS: Merit-based Incentive Payment System (MIPS)
- Advanced APMs: Advanced Alternative Payment Models (Advanced APMS)

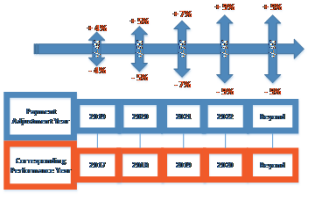
Streamlining legacy programs

Providing 5% incentive to Advanced APM participants

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS):

Performance Period and Payment Adjustments Schedule

- The graph below shows the payment adjustment amounts and schedule for each MIPS performance year through 2020 and beyond.



Note: MIPS will be a budget-neutral program, so all upward and downward adjustments will result in an average change of 0%.

Due to budget-neutrality, there is a potential for 3x the maximum positive adjustment amount per year.

THE QUALITY PAYMENT PROGRAM

ALLOWS EASIER ACCESS FOR SMALL PRACTICES

- Small practices will be able to successfully participate in the Quality Payment Program
- 15 or fewer clinicians

Why?

- Reducing the time and cost to participate
- Providing an on-ramp to participating through Pick Your Pace
- Conducting technical support and outreach to small practices through the forthcoming Quality Payment Program, Small, Rural and Underserved Support (QPP-SURS) as well as through the Transforming Clinical Practice Initiative.

EXCLUSIONS FOR PARTICIPATION, EXCEPTIONS FOR SMALL PRACTICES, AND FEDERAL PROGRAMS

New Providers Established low-volume threshold

- Less than or equal to $30,000 in Medicare Part B allowed charges

OR

- Less than or equal to 100 Medicare patients

Reduced requirements for Improvement Activities performance category

- One high-weighted activity

OR

- Two medium-weighted activities

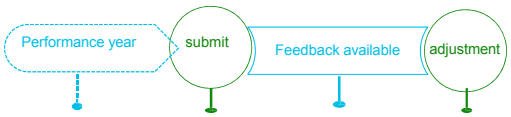
Increased ability for clinicians practicing at:

- Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

To qualify as a Qualifying APM Participant (QP)

Quality Payment Program Overview

WHEN DOES THE MERIT-BASED INCENTIVE PAYMENT SYSTEM OFFICIALLY BEGIN?



2017
Performance Year

Performance: The first performance period opens January 1, 2017 and closes December 31, 2017. During 2017, you will record quality data and how you used technology to support your practice. If an Advanced APM fits your practice, then you can provide care during the year through that model.

March 31, 2018
Data Submission

Send in performance data: To potentially earn a positive payment adjustment under MIPS, send in data about the care you provided and how your practice used technology in 2017 to MIPS by the deadline, March 31, 2018. In order to earn the 5% incentive payment for participating in an Advanced APM, just send quality data through your Advanced APM.

Feedback

Feedback: Medicare gives you feedback about your performance after you send your data.

January 1, 2019
Payment Adjustment

Payment: You may earn a positive MIPS payment adjustment beginning January 1, 2019 if you submit 2017 data by March 31, 2018. If you participate in an Advanced APM in 2017, then you could earn 5% incentive payment in 2019.

FLEXIBLE START FOR CLINICIANS: PICK YOUR PACE

Key Takeaway:
Positive adjustments are based on the performance data on the performance information submitted, not the amount of information or length of time submitted.

Test Pace

- Submit some data after January 1, 2017
- Neutral or small payment adjustment

MIPS Partial Year

- Report for 90-day period after January 1, 2017
- Small positive payment adjustment

Full Year

- Fully participate starting January 1, 2017
- Modest positive payment adjustment

Not participating in the Quality Payment Program for the transition year will result in a negative 4% payment adjustment.
90 day periods do not need to be the same across the three categories

WHAT ARE THE PERFORMANCE CATEGORY WEIGHTS?

Weights assigned to each category based on a 1 to 100 point scale

Transition Year Weights

Quality	Cost	Improvement Activities	Advancing Care Information
60%	0%	15%	25%
Was PQRS	Was VBM	New	Was MU

Note: These are defaults weights; the weights can be adjusted in certain circumstances

MIPS PERFORMANCE CATEGORY WEIGHTS

INDIVIDUAL VS. GROUP REPORTING

OPTIONS

Individual

1. Individual
   under an NPI number and TIN where they reassign benefits

Group

2. As a Group
   a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*
   b) As an APM Entity

** If clinicians participate as a group, they are assessed as group across all 4 MIPS performance categories*

WORKING WITH A THIRD PARTY INTERMEDIARY

Intermediary	Approval Needed	Cost to Clinician
EHR Vendor	EHR Vendors Must be certified by ONC	x
QCDR	QCDRs must be approved by CMS	x
Qualified Registry	Qualified Registries must be approved by CMS	x
CMS Approved CAHPS Vendor	CAHPS Vendors must be approved by CMS	x

ASSESS YOUR FEEDBACK: PREPARE FOR YEAR 2

- The QRUR released on September 26, 2016 (referred to as the 2015 Annual QRUR) is being utilized as the first MIPS performance feedback
- The September 2016 QRURs are available and can be accessed at https://portal.cms.gov/wps/portal/unauthportal/home/
- We encourage physicians and physician groups to access their report and review the quality and cost information to prepare for the Quality Payment Program

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GETTING STARTED…

- Review your 2015 Quality Resource Use Report for guidance.
- Choose a team.. a provider, a medical assistant and a manager.
- Review reporting options with your EHR vendor or registry options through your specialty's academy.
- Choose your pace and the 90 day period you will gather information.
- Choose quality measures and other data wisely, and educate staff.
- Track performance weekly and make adjustments when needed.

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UNDERSTANDING THE MIPS PERFORMANCE CATEGORIES

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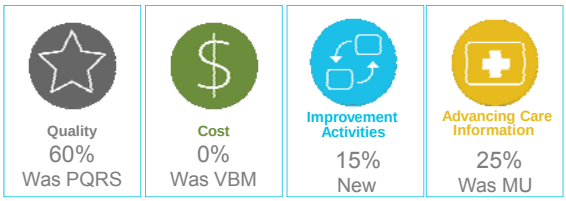
WHAT ARE THE PERFORMANCE CATEGORY WEIGHTS?

Weights assigned to each category based on a 1 to 100 point scale

Transition Year Weights



Note: These are defaults weights; the weights can be adjusted in certain circumstances

EXAMPLE OF 2017 MIPS PARTIAL PARTICIPATION FOR A CARDIOLOGIST

Sample Quality Measures (6, Including 1 Outcome):

1. Closing the referral loop with referring provider
2. Documentation of current medications
3. Statins for primary prevention in high-risk patients and for treatment in patients with known CVD
4. *Chronic anticoagulation therapy for patients with non-valvular atrial fibrillation (AFib) based on CHADS2 risk score
5. *Avoidance of inappropriate cardiac stress imaging in low-risk patients
6. Controlling high blood pressure (outcome measure)

*measure supported by American College of Cardiology

Sample Improvement Activities (2 High-Weighted):

1. Provide 24/7 access to eligible clinicians or groups who have real- time access to patient's medical record.
2. Use of QCDR for feedback reports that incorporate population health.

Advancing Care Information (Use of Technology) Measures (5 Base Score and 1 Performance Score):

1. Security Risk Analysis
2. e-Prescribing
3. Provide Patient Access
4. Send a Summary of Care
5. Request/Accept a Summary of Care
6. Secure Messaging (performance score)

Flexibility to CHOOSE WHAT and HOW you report

Payment adjustments according to composite score

Quality

MIPS PERFORMANCE CATEGORY: QUALITY

- Category Requirements
  - **Replaces PQRS and Quality Portion of the Value Modifier**
  - "Provides for an easier transition due to familiarity

60% of final score

Select 6 of about 300 quality measures (minimum of 90 days to be eligible for maximum payment adjustment); 1 must be:
- Outcome measure OR
- High-priority measure—defined as outcome measure, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination

May also select specialty-specific set of measures

Readmission measure for group submissions that have ≥ 16 clinicians and a sufficient number of cases (no requirement to submit)

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QUALITY: REQUIREMENTS FOR THE TRANSITION YEAR

- Test Pace means...
  - Submitting a minimum amount of data for one measure set for 2017.

- Partial and Full Participation means…
  - Submitting at least six quality measures, including at least one outcome measures, for a full year.

For a full list of measures, please visit qpp.cms.gov

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Quality Measures – Performance vs Reporting

Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

- **Performance Met:** Normal blood pressure reading documented, follow-up not required (G8783)

OR

- **Performance Met:** Pre-Hypertensive or Hypertensive blood pressure reading documented AND the indicated follow-up is documented (G8950)

OR

- **Denominator Exception:** Documented reason for not screening or recommending a follow-up for high blood pressure (G9745)

OR

- **Performance Not Met:** Blood pressure reading not documented, reason not given (G8785)

OR

- **Performance Not Met:** Pre-Hypertensive or Hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given (G8952)

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QUALITY MEASURES

- **Examples of quality performance measures**

1. Diabetes: Hemoglobin A1c (HbA1c) Poor Control(>9%)
   - Only needs to be done **once during the reporting period**. Need to report if either the patient has an A1c above 9 or was not done. If you report that a1c was 7 or between 7-9, you will have reported the measure but not achieve positive performance *(Intermediate outcome measure)*
     - 18-75
     - Dx of diabetes
     - E&M
2. Preventive Care and Screening: Influenza Immunization
   - Can be self-reported by patient
     - Visit between January - March and October - December
     - 2 visits - E&M

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QUALITY MEASURES

- **Examples of quality performance measures**

3. Documentation of Current Medications in the Medical Record
   - Reported on **each** eligible visit *(Intermediate outcome measure)*
     - 18 years or older
     - Every E&M visit
4. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
   - Reported **once** per reporting period
     - 18 years or older
     - E&M
     - Document cessation counseling

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MIPS SCORING FOR QUALITY
(60% OF FINAL SCORE IN TRANSITION YEAR)

Total Quality Performance Category Score = [Points earned on required 6 quality measures] + [Any bonus points] / Maximum number of points*

Quick Tip: Maximum score cannot exceed 100%

*Maximum number of points = # of required measures x 10

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MIPS Scoring for Quality
(60% of Final Score in Transition Year)

Select 6 of the approximately 300 available quality measures (minimum of 90 days)
- Or a specialty set
- Or CMS Web Interface measures
- Readmission measure is included for group reporting with groups with at least 16 clinicians and sufficient cases

Clinicians receive 3 to 10 points on each quality measure based on performance against benchmarks

Failure to submit performance data for a measure = 0 points

Quick Tip: Easier for a clinician that participates longer to meet case volume criteria needed to receive more than 3 points

Bonus points are available

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MIPS SCORING FOR QUALITY
(60% OF FINAL SCORE)

Year 1 participants automatically receive 3 points for completing and submitting a measure

If a measure can be reliably scored against a benchmark, then clinician can receive 3 – 10 points
- Reliable score means the following:
- Benchmarks exists (see next slide for rules)
- Sufficient case volume (>=20 cases for most measures
- Data completeness met (at least 50 percent of possible data is submitted)

If a measure cannot be reliably scored against a benchmark, then clinician receives 3 points
- Easier for a clinician that participates longer to meet case volume criteria needed to receive more than 3 points

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MIPS SCORING FOR QUALITY
(60% OF FINAL SCORE)

More About Benchmarks

- Separate benchmarks for different reporting mechanisms
  - EHR, QCDR/registries, claims, CMS Web Interface, administrative claim measures, and CAHPS for MIPS
- All reporters (individuals and groups regardless of specialty or practice size) are combined into one benchmark
- Need at least 20 reporters that meet the following criteria:
  - Meet or exceeds the minimum case volume (has enough data to reliably measured)
  - Meets or exceeds data completeness criteria
  - Has performance greater than 0 percent

3 POINTS

Why this matters? Not all measures will have a benchmark. If there is no benchmark, then a clinician only receives 3 points.

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MIPS SCORING FOR QUALITY (60% OF FINAL SCORE)

Bonus Points

Clinicians receive bonus points for either of the following:

1. Submitting an additional high-priority measure
   - 2 bonus points for each additional outcome and patient experience measure
   - 1 bonus point for each additional high-priority measure
2. Using CEHRT to submit measures to registries or CMS
   - 1 bonus point for submitting electronically end-to-end

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Advancing Care Information

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MIPS PERFORMANCE CATEGORY: ADVANCING CARE INFORMATION

- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- **Ends and replaces the Medicare EHR Incentive Program (also known as Medicare Meaningful Use)**
- Greater flexibility in choosing measures
- In 2017, there are *2 measure sets for reporting based on EHR* edition:
  - Advancing Care Information Objectives and Measures
  - 2017 Advancing Care Information Transition Objectives and Measures

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MIPS PERFORMANCE CATEGORY: ADVANCING CARE INFORMATION

BASE SCORE	+	PERFORMANCE SCORE	+	BONUS SCORE	=	FINAL SCORE
Account for 50% of the total **Advancing Care Information Performance** Category Score		Account for up to 90% of the total **Advancing Care Information Performance** Category Score		Account for up to 15% of the total **Advancing Care Information Performance** Category Score		Earn 100 or more percent and receive FULL 25 points of the total Advancing Care Information Performance Category Final Score

The overall Advancing Care Information score would be made up of a base score, a performance score, and a bonus score for a maximum score of 100 percentage points

Advancing Care Information Requirements for the Transition Year

0

Submit Something

Test pace means…

- Submitting 4 or 5 base score measures
  - Depends on use of 2014 or 2015 Edition
- Reporting *all* required measures in the base score to earn any credit in the advancing care information performance category

+% Submit a partial year

+% Submit a Full Year

Partial and full participation means...

- Submitting more than the base score in year 1

MIPS SCORING FOR ADVANCING CARE INFORMATION (25% OF FINAL SCORE): BASE SCORE

50%

Base score (worth 50%)

Clinicians must submit a numerator/denominator or Yes/No response for each of the following required measures:

Advancing Care Information Measures

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Send a Summary of Care
- Request/Accept a Summary of Care

2017 Advancing Care Information Transition Measures

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Health Information Exchange

0% Failure to meet reporting requirements will result in base score of zero, and an advancing care information performance score of zero.

MIPS Scoring for Advancing Care Information (25% of Final Score): Performance Score

90% Performance Score (worth up to 90%)

- Report up to 9 Advancing Care Information measures

OR

- Report up to 7 2017 Advancing Care Information Transition Measures

Each measure is worth 10-20%.
The percentage score is based on the performance rate for each measure:

Performance Rate 1-10	1%
Performance Rate 11-20	2%
Performance Rate 21-30	3%
Performance Rate 31-40	4%
Performance Rate 41-50	5%
Performance Rate 51-60	6%
Performance Rate 61-70	7%
Performance Rate 71-80	8%
Performance Rate 81-90	9%
Performance Rate 91-100	10%

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2017 ACI Measures

Base
1. Protect patient health information
2. e-Prescribing
3. Health information exchange
4. Provide patient access

Performance
5. Patient-specific education
6. View, download, or transmit
7. Secure messaging
8. Medication reconciliation
9. Immunization registry reporting

Bonus
- Syndromic surveillance reporting
- Specialized registry reporting
- Report certain IAs using EHR

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ACI: Exceptions

- ACI automatically reweighted to zero for:
  - Hospital-based ECs (75%+ of services at POS 21, 22, 23)
  - Non-patient facing clinicians
  - Non-physicians
- Other clinicians may apply for a hardship exception for one or more for the following reasons:
  - Insufficient Internet Connectivity
  - Extreme and Uncontrollable Circumstances
  - Lack of Control over the Availability of CEHRT
- CMS will no longer automatically exclude clinicians based on specialty designation

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MIPS SCORING FOR ADVANCING CARE INFORMATION (25% OF FINAL SCORE): BONUS SCORE

for reporting on any of these Public Health and Clinical Data Registry Reporting measures:

- Syndromic Surveillance Reporting
- Electronic Case Reporting
- Public Health Registry Reporting
- Clinical Data Registry Reporting

5% BONUS

10% BONUS for using CEHRT to report certain Improvement Activities

MIPS PERFORMANCE CATEGORY: ADVANCING CARE INFORMATION

BASE SCORE	+ PERFORMANCE SCORE	+ BONUS SCORE	= FINAL SCORE
Account for 50% of the total **Advancing Care Information Performance** Category Score	Account for up to 90% of the total **Advancing Care Information Performance** Category Score	Account for up to 15% of the total **Advancing Care Information Performance** Category Score	Earn 100 or more percent and receive FULL 25 points of the total Advancing Care Information Performance Category Final Score

The overall Advancing Care Information score would be made up of a base score, a performance score, and a bonus score for a maximum score of 100 percentage points

Improvement Activities

MIPS PERFORMANCE CATEGORY: IMPROVEMENT ACTIVITIES

- Attest to participation in activities that improve clinical practice
  - Examples: Shared decision making, patient safety, coordinating care, increasing access
- *Clinicians choose* from 90+ activities under 9 subcategories:

1. Expanded Practice Access
2. Population Management
3. Care Coordination
4. Beneficiary Engagement
5. Patient Safety and Practice Assessment
6. Participation in an APM
7. Achieving Health Equity
8. Integrating Behavioral and Mental Health
9. Emergency Preparedness and Response

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Improvement Activity Requirements for the Transition Year

Test Pace means…

- Submitting 1 improvement activity
  - Activity can be high weight or medium weight

Partial and full participation means…

- Choosing 1 of the following combinations:
  - 2 high-weighted activities
  - 1 high-weighted activity and 2 medium-weighted activities
  - At least 4 medium-weighted activities

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Improvement Activities

Activity	Weight	Points
Provide 24/7 access to clinicians for urgent care	High	20
Participate in an AHRQ-listed patient safety organization	Medium	10
Regularly assess the patient experience of care through surveys, advisory councils, and/or other mechanisms.	Medium	10
	Total score:	**40 / 40**

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IMPROVEMENT ACTIVITIES

- **Examples of improvement activities (abbreviated)**

1. Expanded Practice Access
   - Provide 24/7 access to clinicians with access to patient records (HIGH)
   - Use of telehealth services and analysis of data (MEDIUM)
2. Population Management
   - Participation in systematic anticoagulation program (HIGH)
   - Participate in a Rural Health Clinic (HIGH)
   - Use of QCDR to generate regular performance feedback (HIGH)
3. Care Coordination
   - Implementation of regular care coordination training (MEDIUM)
   - Timely communication of test results & follow up (MEDIUM)
   - Establish effective care coordination and active referral mgmt (MEDIUM)

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MIPS SCORING FOR IMPROVEMENT ACTIVITIES

(15% of Final Score in Transition Year)

$$\text{Improvement Activities Performance Category Score} = \left[\frac{\text{Total number of points scored for completed activities}}{\text{Total maximum number of points (40)}}\right] \times 100$$

Quick Tip: Maximum score cannot exceed 100%

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MIPS PERFORMANCE CATEGORY: COST

- No reporting requirement; 0% of final score in 2017
- Clinicians assessed on Medicare claims data
- CMS will still provide feedback on how you performed in this category in 2017, but it will not affect your 2019 payments.
- *Keep in mind:*

Uses measures previously used in the Physician Value-Based Modifier program or reported in the Quality and Resource Use Report (QRUR)	Only the scoring is different

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MIPS PERFORMANCE CATEGORY WEIGHTS

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Surveillance

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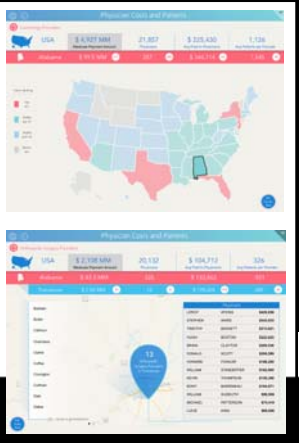
DIGITAL CORRAL



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MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS):

Performance Period and Payment Adjustments Schedule

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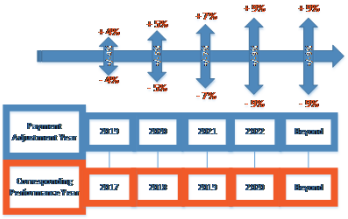

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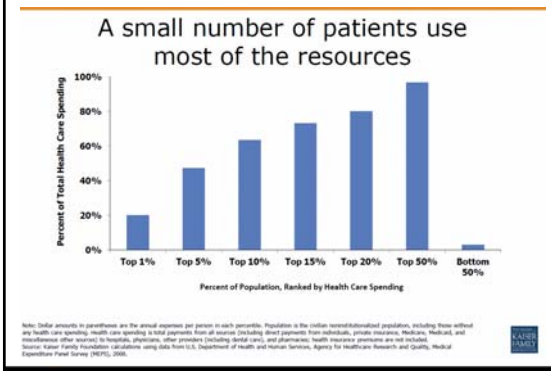
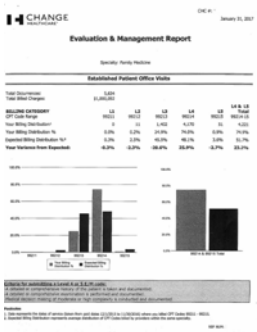
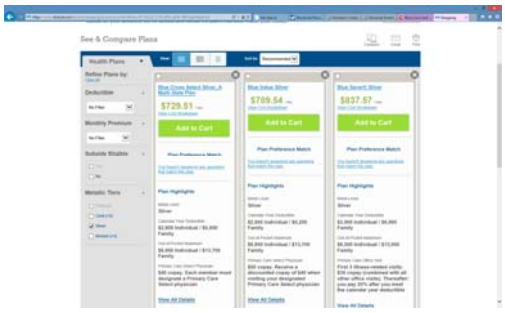
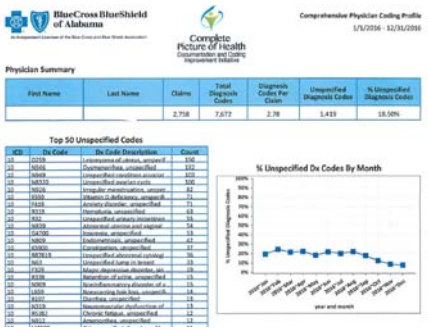


DIGITAL CORRAL-PREPAY/POST REVIEW AUDIT



GATEKEEPER-REFERRAL NEEDED





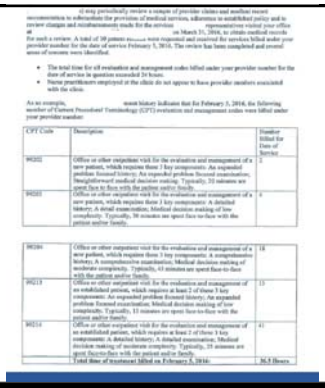
- Example: 68 year old man with pneumonia, emphysema, diabetes with retinopathy, and respiratory failure.

ICD 10 Code	Relative Risk Score
J13: Pneumococcal pneumonia	0.200
J43.9: Other emphysema	0.346
J13.39 Diabetes with ophthalmic manifestations	0.368
J96.00: Acute respiratory failure	1.329
Demographic Component	
68 Year Old Male	0.288
Relative Risk Score	**1.531**

If this member's risk score is 1.531, he is 53 % more complex than the average patient.

One missing diagnosis code and one unspecified code reduces the relative risk score by 61%

ICD 10 Code	Relative Risk Score
J13: Pneumococcal pneumonia	0.200
~~J43.9: Other emphysema~~	~~0.346~~
J13.39 Diabetes with ophthalmic manifestations	0.118
J96.00: Acute respiratory failure	1.329
Demographic Component	
68 Year Old Male	0.288
Relative Risk Score	**0.935**



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REFERENCES

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CMS.GOV
MGMA.ORG/MACRA
DELOITTE

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Profile

Sae joined Warren Averett in 2006 and has more than twelve years of public accounting experience. Sae is a Member in the Firm's Healthcare Consulting Group and specializes in working with medical practices. He serves physicians in matters such as compensation and incentive plans, merger and acquisition transactions, business advisory and personal income tax planning. Sae also has expertise in medical real estate issues including feasibility analysis, cost segregation studies and tax planning for purchase/sale transactions.

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Profile

Maddox Casey is a Member of the Firm in the Healthcare Division of the Birmingham office. He has been with the Firm since 2004 and serves as the firm-wide Service Area Leader for the Healthcare Client Practice Group, serving over 650 Physician clients across 18 offices with revenues over $4M. He also serves as the Co-Chair of Warren Averett Healthcare Reform Committee, and manages all client related communication on reform including email alerts, external seminars and internal training. Maddox focuses his practice on medical practice profitability, physician ownership design, compensation structure, healthcare reform and other professional services. Maddox recently served as a Facilitator for the 2015 Warren Averett Leadership Development Program, in which he helped provide coaching and leadership for the 22 upcoming professionals.
plans

Professional affiliations include:

- American Institute of Certified Public Accountants
- Alabama Society of Certified Public Accountants
- Local and State Medical Group Management Association

Warren Averett
CPAs AND ADVISORS

JIM STROUD, CPA

Member

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Profile

Jim Stroud has been with Warren Averett since 1988 and is a member of the Firm's Healthcare Consulting Group. With over 30 years of accounting and consulting experience, Jim represents a diverse client base spanning various industries. Jim specializes in comprehensively serving medical practices, striving to make each practice operate as efficiently and effectively as possible. Jim facilitates monthly Practice Management Roundtables designed to identify and discuss feasible solutions to daily practice management issues. He also serves as facilitator for employee and physician retreats and is a frequent speaker to various medical groups.

Areas of special emphasis include:

- Strategic planning for medical practices
- Employee and physician retreats
- Business succession planning
- Profitability enhancement
- Retirement plan design
- Contractual arrangements
- Physician and staff compensation formula models and incentive plans

Professional affiliations include:

- American Institute of Certified public Accountants
- Alabama Society of Certified Public Accountants
- Birmingham Area Chamber of Commerce, Lifetime Member
- Local, State and National Medical Group Management Association Member

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