DEMYSTIFYING MACRA, QPP AND MIPS

eBook

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DEMYSTIFYING MACRA, QPP AND MIPS

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introduction

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a very important but not yet widely understood piece of legislation. In fact, 50% of the surveyed physicians say they have never heard of the law and 32% are not familiar with the requirements, according to research from the Deloitte Center for Health Solutions (2016)[1]. However, it would be appropriate for physicians to become in-the-know quickly, as it will take effect in 2019. On October 14, 2016, the Centers for Medicare and Medicaid Services (CMS) released the final rule for one of the greatest changes to Medicare in decades.

What MACRA has done is replace the Medicare Part B Sustainable Growth Rate (SGR) and create a new method regarding how Medicare reimburses physicians. CMS made new changes to the Physician Fee Schedule (PFS) and replaced the fee-for-service method with value-based payments under the Quality Payment Program (QPP). The QPP is made up of two major sections: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs). CMS estimates that around 600,000 Part B physicians will fall under MIPS. MIPS will now be the “new norm” for Part B physicians who will only be exempt if they meet certain conditions.

While this may seem like a lot to take in, we have broken down the Quality Payment Program portion of MACRA for a high-level overview. This eBook explains how MACRA affects each individual and group, how each individual and group reports, and how it will impact each business and practice.

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WHAT IS THE QUALITY PAYMENT PROGRAM?

The Quality Payment Program (QPP), put simply, has the goal to improve Medicare by allowing physicians to concentrate on the quality of care they are providing their patients, as well as other benefits QPP intends to achieve.

Some of those benefits include:

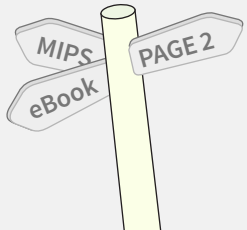
1. Reducing the burden on providers
2. Maintaining independent clinical practices
3. Promoting existing efforts of Delivery System Reform

The QPP will replace and streamline the existing independent programs of Meaningful Use, PQRS and value-based programs. To have long-term success, the QPP must take into consideration diversity in care delivery and provide options that work for both physicians and their patients. CMS predicts the QPP to change and evolve over time, and with that, has provided a 60-day comment period to allow physicians and patients to contribute their input.

If ready, one can begin as soon as they'd like. As of January 1, 2017, physicians can start collecting their performance data, should they desire. If choosing to wait, any time before October 2, 2017, is an acceptable date to begin. Regardless of start date, performance data must be submitted by March 31, 2018. The first performance-based payment adjustments will begin the first of the year in 2019.

important dates

- **January 1, 2017**
  Physicians can start collecting their performance data.
- **October 2, 2017**
  Last date to begin collecting data.
- **March 31, 2018**
  Last day for submitting data regardless of start date
- **January 1, 2019**
  First performance-based payment adjustments will begin



WHO CAN PARTICIPATE IN THE QPP?

There are two tracks that make up QPP: the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (Advanced APMs or just APMs).

What is MIPS?

If you decide to participate in traditional Medicare, rather than an Advanced APM, then you will participate in MIPS where you earn a performance-based payment adjustment to your Medicare payment.

MACRA replaced three Medicare reporting Programs with MIPS (Medicare Meaningful Use, the Physician Quality Reporting System, and the Value-Based Payment Modifier).

What are Alternative Payment Models?

An Alternative Payment Model (APM) is a payment approach, developed in partnership with the clinician community, that provides added incentives to the clinician to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

The vast majority of clinicians must participate in the QPP in either the MIPS or Advanced APMs:

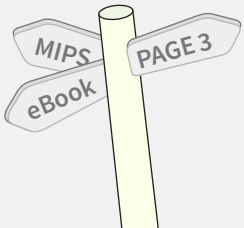
- Physicians (Doctors of Medicine, Osteopathy, Podiatric Medicine, Optometry, Doctors of Dental Surgery or Medicine, and Chiropractors)
- Physician Assistants (PAs)

- Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Clinical Nurse Specialists

While that covers quite a few health care providers, there are some who are exempt from the QPP in 2017:

- Providers in their first year of Medicare (in 2017)
- Providers who treat less than 100 Medicare patients per year
- Providers who bill $30,000 or less in Medicare claims per year
- Providers who are currently attesting for Medicaid Meaningful Use

If you decide to participate in traditional Medicare, rather than an Advanced APM, then you will participate in MIPS where you earn a performance-based payment adjustment to your Medicare payment.



HOW DO ELIGIBLE CLINICIANS PARTICIPATE?

MIPS track

Under the MIPS track, eligible clinicians may earn a performance-based reimbursement adjustment from Medicare based on four categories: Improvement Activity (15%), Advancing Care Information (25%), Quality (60%), and Cost (0% for 2017, but will be weighted from 2018 forward). Each must be fulfilled for a minimum of 90 days. Let's take a look at each category in depth.

1. **Improvement Activity:** For the majority of participating clinicians, the Improvement Activity requirement is to prove that they have completed up to four improvement activities for the required period of time. There are exceptions, however. With a group of less than 15 members or if the respective participant(s) is in a rural location, the requirement lowers to two completed improvement activities. If the participant practices in a certified patient-centered medical home, they receive full credit by default. There are 93 improvement activities to select from and clinicians can choose the activities that best suit their practice.
2. **Advancing Care Information:** This is the requirement that replaces the EHR Incentive Program's Meaningful Use requirements. To be eligible, one must complete certain measures: request/accept summary of care, send summary of care, security risk analysis, provide patient access and prescribe electronically. There is also the option to accomplish nine measures within this time period to be eligible for extra credit. In 2017, there are two measure set options for reporting. The option you use to submit your data is based on your electronic health record edition. The Advancing Care Information Objectives, which includes 15 measures, is the first option, and if you have technology certified to the 2015 Edition Certification Requirements or a combination of 2014 and 2015 Editions that support the measures, then you can also use this option. The 2017 Advancing Care Information Transition Objectives and Measures, which includes 11 measures, is your second option and can be used if you have technology certified to the 2015 or 2014 Edition or you have a combination of 2014 and 2015 Editions that support these measures.
3. **Quality:** This is the requirement that replaces the PQRS program. To meet this requirement, one must report six quality measures, including one outcome measure to CMS. There are over 250 measures to choose from and 80% of those are tailored to specialists. Not all measures in each Specialty Measure Set will be applicable, or relevant, to the clinician's services or care rendered, so referring to the measures specifications will help the eligible clinician verify which measures make sense to their practice. If the set includes less than six applicable measures, the eligible clinician should only report on the measures that are applicable.
4. **Cost:** This requirement replaces the Value-Based Modifier program. For 2017, no data submission is required but it will be calculated from adjudicated claims. Starting in 2018 and beyond, it will be weighted, but that exact weight is undetermined at this time.

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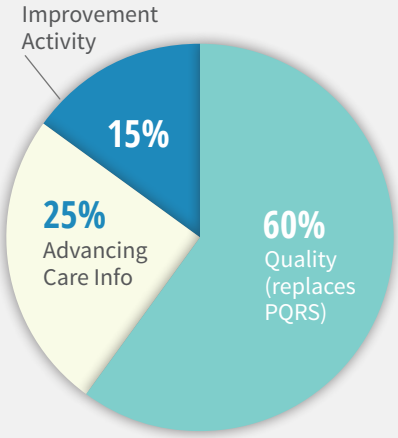
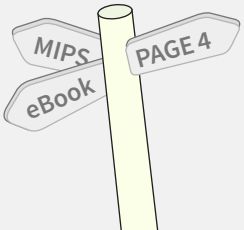
four categories for

Eligible Clinicians to Earn Performance-Based Reimbursement



*Cost (0% for 2017, but will be weighted from 2018 forward)



how do eligible clinicians participate continued

APMs track

An Alternative Payment Model (APM) provides incentive payments to encourage high-quality care at an efficient price. Advanced APMs are a subcategory of APMs and allow practices to earn more by putting themselves at a sort of risk with their patients' outcomes. If a clinician chooses to participate in an Advanced APM, they have the potential to earn a Medicare incentive payment for taking part in a progressive payment model. Should a clinician receive 25% of Medicare payments or treat 20% of Medicare patients through an Advanced APM, they have the potential to earn a 5% incentive payment in 2019. It is predicted that an average of 70,000 to 120,000 clinicians will qualify for the 5% incentive bonus.

To meet the Advanced APMs requirements one must meet the following criteria:

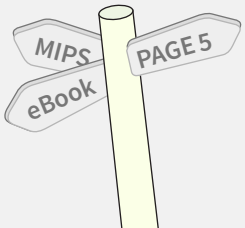
- Be CMS Innovation Center models, Shared Savings Program tracks, or select federal demonstration programs
- Require participants to utilize certified, select EHR technology
- Base service payments on measures such as the MIPS quality measures
- Be a Medical Home Model expanded under Innovation Center authority or require participants to bear more than nominal financial risk for losses

In 2017, these are the Advanced APMs that clinicians can potentially earn the 5% bonus by participating in:

- Comprehensive ESRD Care (CEC) – Large Dialysis Organization (LDO)
- Comprehensive ESRD Card – Non-LDO
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Shared Savings Program – Track 2
- Shared Savings Program – Track 3
- Oncology Care Model (two-sided risk arrangement)

This list will continue to transform as more models are suggested and developed with help from the medical community.

It is predicted that an average of 70,000 to 120,000 clinicians will qualify for the 5% incentive bonus.



HOW DOES IT AFFECT MY MEDICARE PAYMENTS?

Medicare payments may be adjusted up, down or simply stay the same, depending on which track of QPP is selected, the amount of data submitted by March 31, 2019, and how the clinician(s) perform. For example, if an eligible clinician (EC) does not participate, there will be a negative 4% payment adjustment. If the EC submits a very small amount of 2017 data (perhaps one quality measure), it is possible to avoid a negative adjustment. If 90 days' worth of 2017 data is submitted, payments may either stay the same or be adjusted slightly up. Finally, if a full year of 2017 data is submitted, a significantly positive payment adjustment is possible. It all depends on how much data is submitted and the quality of the outcomes.

Your Choices

-4

Non-participation

There will be a negative 4% payment adjustment for healthcare professionals who don't participate in QPP.

0

Minimal participation

If there is a very small amount of 2017 data submitted, it is possible to avoid a negative adjustment.

0+

Partial participation

If 90 days' worth of 2017 data is submitted, payments may either stay the same or be adjusted slightly up.

Full participation

If a full year of 2017 data is submitted, a significantly positive payment adjustment is possible.

REPORTING OPTIONS

Reporting as an Individual

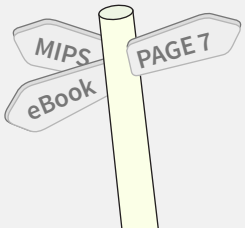
If one chooses to send their data as an individual rather than as a group, their payment adjustment will be determined based solely on their performance. An individual is considered to be a single National Provider Identifier (NPI) that correlates with a single Tax Identification Number (TIN). When reporting as an individual, the clinician must send their own individual data for each category in MIPS through either a certified electronic health record (EHR), a claims-based registry or a qualified clinical data registry. It is also possible to send data through the normal Medicare claims process, which may be an easier route for some.

Reporting as a Group

Reporting as a group can be a simpler option for many clinicians, and it appears it may just get easier as time progresses. If clinicians decide to send their data together as a group, they will then receive one payment adjustment, judged by the entire group's performance. A "group" consists of several clinicians who share the same Tax Identification Number (TIN), regardless of their individual specialties or practice sites. The group will submit group-level data set for each MIPS category by way of the CMS website; or a certified electronic health record, registry or qualified clinical data registry just like individual reporters do. However, to submit data as a group through the CMS web interface, the group must be registered as such by June 30, 2017.

An upcoming addition that shows great promise is the ability to be a part of "virtual groups" in upcoming years (no set date on that, yet). Individual clinicians, along with groups of 10 or less, will have the chance to form said groups. Each member must indicate that they are participating through a virtual group before the beginning of the related performance period. CMS will establish and enforce further policies for these virtual groups when the time comes.

Reporting as a Group can be a simpler option for many clinicians, and it appears it may just get easier as time progresses.



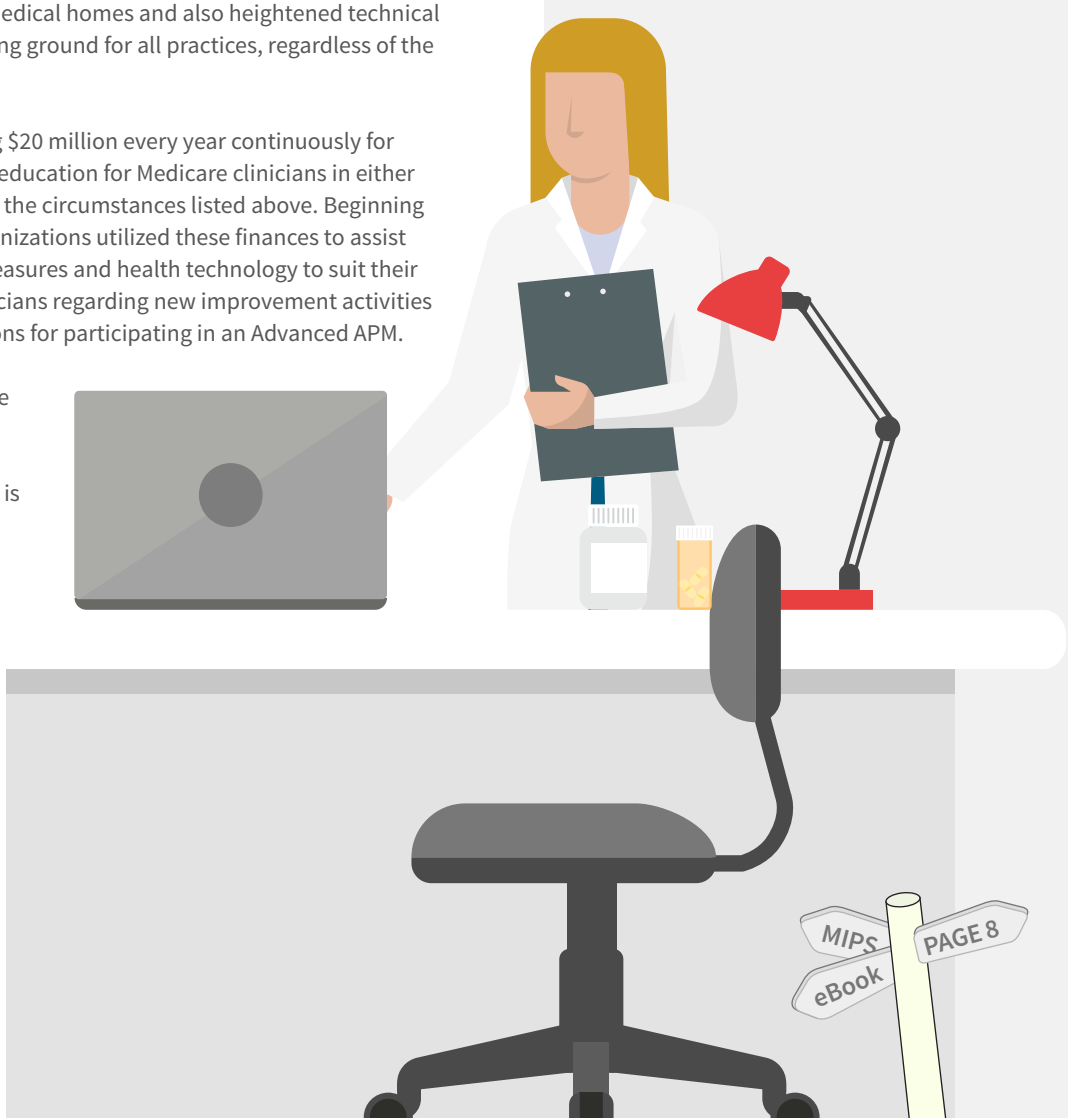
SUPPORT FOR SMALL PRACTICES

Some small practices do still receive benefits from the Quality Payment Program (QPP), as small practices are also crucial to maintaining an excellent healthcare industry. Small practices are those practices with 15 or fewer clinicians and practices located in rural areas or in underserved areas. The QPP provides options for those clinicians to make it easy to report their performance and qualify for incentives. It's projected that physicians who report their performance have the ability to perform on the same level, if not exceed, how mid-sized or large practices operate. The amount and percentage of small practices participating in the Quality Payment Program are also predicted to rise and even exceed participation in legacy programs (such as PQRS) because of a few different reasons:

- A lesser burden on reporting
- Increased usability of technology
- Advanced technical assistance

As mentioned at the beginning of this eBook, there are many benefits in the final rule to assist smaller practices. There are exemptions for practices with a smaller volume, certain allowances for patient-centered medical homes and also heightened technical support. The goal is to have an even playing ground for all practices, regardless of the situation.

MACRA takes it a step further by offering $20 million every year continuously for five years in order to finance training and education for Medicare clinicians in either individual or smaller group practices with the circumstances listed above. Beginning December of 2016, local experienced organizations utilized these finances to assist small practices in choosing the quality measures and health technology to suit their individualized needs. They also train clinicians regarding new improvement activities and help practices in assessing their options for participating in an Advanced APM. Making these tools available for small or underserved practices so they can become familiar with new programs is essential to ensuring the practices have the chance to get back to the business of healing, which is always the top priority.



WHERE DO I GO FOR SUPPORT WITH QPP?

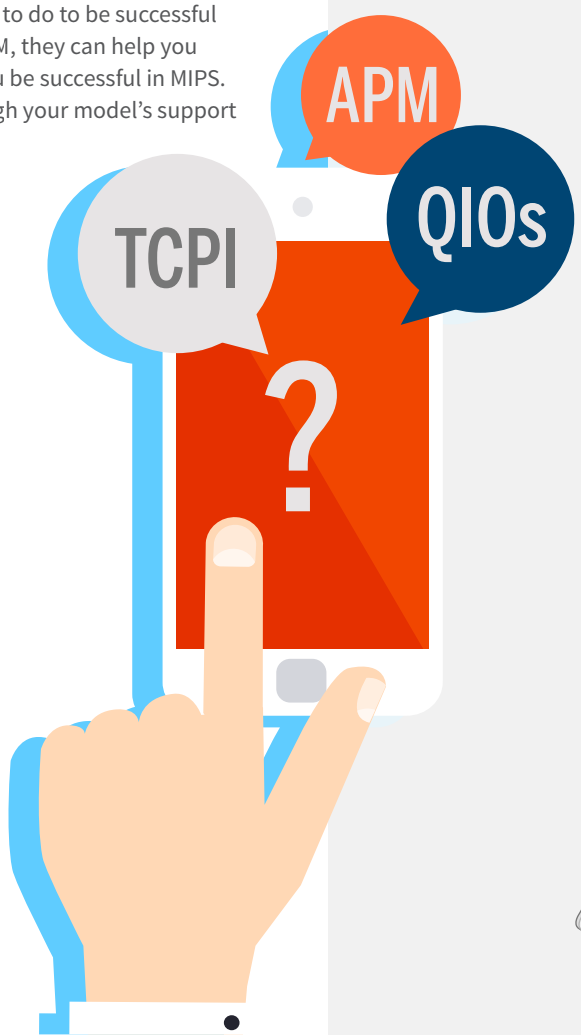
CMS has created a new Quality Payment Program website to help explain and assist clinicians in identifying measures and activities that make the most sense to their practice or specialty, while also supporting organizations on the ground to better assist clinicians who are eligible for the program.

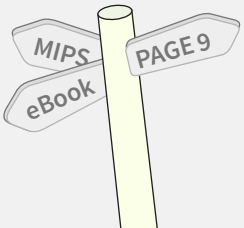
Currently there are three programs that are available:

Transforming Clinical Practice Initiative (TCPI): This initiative is designed to help clinician practices in sharing, adapting and developing their comprehensive quality improvement strategies. Clinicians that participate in TCPI will have the advantage of learning about MIPS and how to move toward participating in Advanced APMs.[2]

Quality Innovation Network (QIN) – Quality Improvement Organizations (QIOs): This program brings Medicare beneficiaries, providers and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care and improve clinical quality.[3]

APM Learning Systems: If you're in an APM, the Innovation Center's Learning Systems can help you find specialized information about what you need to do to be successful in the Advanced APM track. Even if you are not an Advanced APM, they can help you understand the benefits you have through your APM to help you be successful in MIPS. More information about the Learning System is available through your model's support inbox.





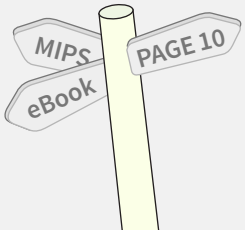
SCORING AND PAYMENT ADJUSTMENTS

MIPS scores are based on the four individual performance categories added together for a single composite score on a 0 to 100 point scale. Each category is scored separately as a percentage of maximum possible performance in the category. The end score will then be compared to the MIPS performance three-point threshold. In order to receive the entire three points, eligible clinicians must achieve at least a score of 70. This will then decide how the Medicare payment adjustments will be made. In the initial year, the highest adjustment possible is 4% (positive or negative); however, there is the chance to be an "exceptional performer". An exceptional performer can receive an additional bonus of up to three times the regular adjustment. This means that the initial year can actually be up to 12% for these select performers. In 2022, the positive adjustment is projected to increase to up to 27% for exceptional performers.

MIPS composite performance scoring consists of:

- The weight of each category
- Exceptional performance
- Availability of measures for each category of clinicians
- Group performance
- Whether the practice is exceptionally small or located rurally

In 2022, the positive adjustment is projected to increase to up to 27% for exceptional performers.



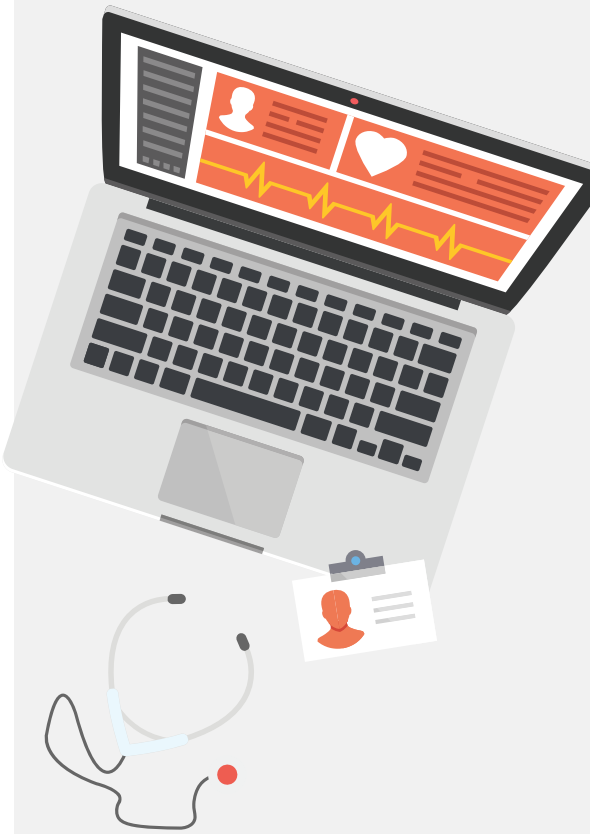
THE MACRA IMPACT ON THE EHR

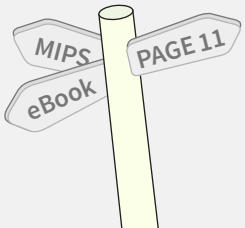
The use of an electronic health record (EHR) is at the very center of the QPP part of MACRA, with both MIPS and Advanced APMs now requiring the use of Certified EHR Technology (CEHRT) in order to qualify for positive Medicare payment adjustments. Meaningful Use is undoubtedly becoming less and less relevant as an individual program; however, it still holds a lot of weight with MIPS requirements and the technology needed to complete them. Under the MACRA proposed rule, EHR technology must meet the 2015 Edition Health IT Certification Requirements after 2017, which also stress the importance of using application programming interfaces (APIs) to ensure ideal uses of clinical health data. However, recent studies have shown that more than 75% of providers participating in the Medicare EHR Incentive Program as of July 2016 were using 2014-certified-edition technology. **With that being said, IT vendors will need to adapt quickly and alter their platforms to make sure they're in line with the 2015 certifications requirements.**

Concerning the use of CEHRT and APIs, they should encourage and provide an ideal environment where providers can excel in managing a population's health, while also creating analytics-based methods to deliver treatment to patients. At the same time, these APIs should make the health data that has been generated by each patient contribute more easily to the full picture of a patient's health status. While there are many new changes, CMS has made it clear that these new regulations are all based on patient-centric care and providing the best level of care for the patient.

This new technology requirement will hit smaller practices much harder than the mid-sized or bigger ones. Many smaller practices have invested in EHR that may not be evolving at a rate required to meet these changing requirements. Many have invested in EHR vendors who are the most cost-effective, but as MACRA doesn't require the vendors to update their technology to the 2015 version, many physicians will be in a tight situation. **Regardless, each practice must meet the MACRA requirements before January 1, 2018.**

While the new EHR requirements may be a burden for some, overall it is a step in the right direction. Utilizing an EHR that has excellent systems integration and interoperability will make the transition much more seamless. With simplified billing and accelerated payment options, it will not only be easier on practices, but on patients as well. Find one that can also help with the reporting process and that's one less burden to worry about in a time with so many changes and new regulations.



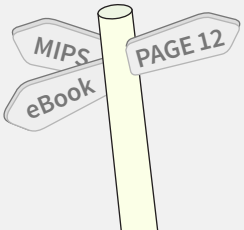


PRACTICE IMPACTS

MACRA will have a different impact on each practice and on many individuals, depending on a variety of factors. Ultimately, the implication of MACRA can cause a business or practice to succeed or to fail. The Centers for Medicare and Medicaid Services (CMS) predict that approximately 712,000 clinicians will be impacted by QPP changes, just in 2017 alone. This is likely to change in upcoming years, as there will be more changes as time progresses. 2017 is the perfect year for a "practice run" and for making sure each practice is aware of which reporting track they fall into and if they meet all of the requirements beforehand.

One factor to note is that all MIPS performance data will be publicly available. This can have either a positive or negative effect on businesses, depending on the type of scores they receive and in which areas. This also encourages accountability and patient success. Clinician and group performance scores will be available on the Physician Compare website or the downloadable database from CMS. The composite scores and scores for each category will be available. However, CMS has suggested a 30-day buffer period before any of the data is published to give clinicians the opportunity to review and submit possible corrections before the data is made available to the public.

MACRA requires clinicians to comprehend and carry out a very complex new payment system, which is based on value not on volume. It is also currently unclear how the MACRA rules will apply to hospital-based clinicians, so there will be a lot of time and resources spent educating each clinician and practice. **Ultimately, payment is dependent upon patient success.** This is what CMS is aiming to do and theoretically, it should lower the occurrences of malpractice and increase overall patient health. While that sounds like a simple and noble concept, there are also some potential snags. Many providers will be under financial pressure when determining what will be best for their patients on a daily basis.



CONCLUSION

Through open communication among practices and clinicians, the QPP and MACRA will undoubtedly develop for the better over the coming years, with patient care, as well as the well-being of clinicians, in mind . The over 900-page piece of legislation will be confusing for many; however, there are organizations on the ground to provide help to QPP-eligible clinicians. It will affect many businesses, both in a positive and negative manner, but with each passing year, the law aims to benefit both patients and clinicians, together, while focusing on what is most important. So, while currently less than half of physicians actually understand what the Medicare Access & CHIP Reauthorization Act is and what it does, that number is steadily rising.

About Henry Schein MicroMD

Henry Schein MicroMD, a subsidiary of Henry Schein, Inc., provides simple yet powerful EMR and Practice Management solutions that facilitate the delivery of superior patient care, automate incentive and quality reporting activities, and streamline operations for today's busy providers. Full-featured, time-tested, and budget-friendly, MicroMD EMR is 2014 Edition Complete Ambulatory certified software that helps small practices, large medical groups, community health centers, and billing services accelerate progress toward a paperless environment and health information exchange with minimal disruption and stress. **Learn more at www.micromd.com.**

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2. https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/
3. http://qioprogram.org/contact-zones?map=qin

Additional Resources

- MIPS Program Performance: https://qpp.cms.gov/measures/performance
- Quality Measures: https://qpp.cms.gov/measures/quality
- Advancing Care Information: https://qpp.cms.gov/measures/aci
- Improvement Activities: https://qpp.cms.gov/measures/ia
- QPP Educational Resources: https://qpp.cms.gov/resources/education
- https://ehrintelligence.com/features/what-is-macra-and-what-it-means-to-providers-ehr-technology
- https://www.advisory.com/research/physician-practice-roundtable/members/expert-insights/2016/nine-faqs-on-provider-payment-under-macra