MACRA
What you need to know!

Medical Oncology Association of Southern California

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Agenda

- MACRA Overview
- PQRS
- EHR
- Resources

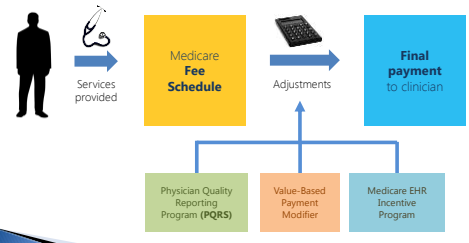
What is MACRA?

MACRA stands for the **Medicare Access and CHIP Reauthorization Act** of 2015, bipartisan legislation signed into law on April 16, 2015.

- Repeals **Sustainable Growth Rate (SGR) formula**
- Changes Medicare PFS Payment
  - Two Payment pathways reward value over volume
    - Track 1: Merit-Based Incentive Payment System **(MIPS)**
    - Track 2: Incentives for Alternate Payment Model **(APM)**
- Streamlines PQRS, VM and EHR programs into 1 new system (MIPS)
- Incentivizes involvement in Alternative Payment Models (APMs)

How does Medicare Part B pay me now?

The **current** system:



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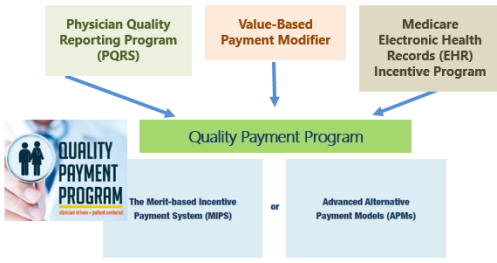
Medicare Reporting under MACRA

MACRA streamlines these programs into The **Quality Payment Program.**



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MACRA Final Rule

- Restores the 0.5 percent payment update for 2017
- Reduces the number of measures that must reported, from 30 to 15
- Physicians pick their pace of participation
  - Can report for 90 days in 2017 to receive a bonus
- Providers will not be scored on "resource use" (physician cost) in 2017
- Eliminates the pass/fail system and will provide proportional credit.
- Expands the types of alternative payment models (APM)
  - Track 1 ACOs.
  - Reduces the financial risk requirements for APMs.

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When and where do I submit comments?

- Comment Period closes December 19th
  - Code CMS-5517-FC
- Submit electronically through
  - regulations.gov
  - regular mail
  - by express or overnight Mail
  - By hand or courier
- Instructions www.qpp.cms.gov

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MACRA Eligible Clinicians

- Participate in Medicare Part B as Individual or Group
- 2019 & 2020 (First two years)
  - Physicians, PAs
  - Certified Registered Nurse Anesthetists
  - NPs, Clinical Nurse Specialists
  - Groups that include such professionals
- 2021 onward
  - Secretary can add EPs (described in 1848(k)(3)(B)) to MIPS
- Does not apply PART A, facilities or hospitals **

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Who will NOT Participate in MIPS?

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

FIRST year of Medicare Part B participation

Below low patient volume threshold

Certain participants in ADVANCED Alternative Payment Models

Medicare billing charges of $30,000 or less in a given year **OR** see fewer than 100 Medicare Part B patients

Note: MIPS **does not** apply to hospitals or facilities

The Quality Payment Program

The Merit-based Incentive Payment System (MIPS)

or

Advanced Alternative Payment Models (APMs)

One Path to Quality:

The Merit-based Incentive Payment System (MIPS)

MIPS: What will be involved?

- ✓ **MIPS is a new program**
  - **Streamlines 3 currently independent programs to work as one and to ease clinician burden.**
  - **Adds a fourth component to promote ongoing improvement and innovation to clinical activities.**

- ✓ **MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.**

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The cost category will be calculated in 2017, but will not be used to determine your payment adjustment. In 2018, we will start using the cost category to determine your payment adjustment.

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MIPS composite performance score 4 weighted categories

Year	Quality Measures	Resource Use	Clinical Practice Improvement Activities ***	Advancing Care Information	MIPS Adjustment Factor (+/-)
2019	60%		15%	25%	+/- 4%
2020	45%	15%	15%	25%	+/- 5%
2021	30%	30%	15%	25%	+/- 7%
2022 beyond	30%	30%	15%	25%	+/- 9%

- The composite performance score will range from 0-100
- The MIPS composite performance score will factor in performance in 4 weighted categories: No Cost Category for 2019
- EPs receive positive adjustment factor if score above performance threshold or negative adjustment if below threshold

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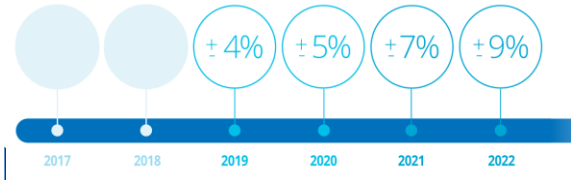
How much can they adjust my payment?

Based on a composite performance score, clinicians will receive **+/- or neutral** adjustments **up to** the percentages below:

MIPS Composite Performance Score → **Adjusted** Medicare **Part B payment** to clinician



Adjustment increases each year from ***2019 to 2022***

INCENTIVES FOR ADVANCED APM PARTICIPATION

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Advanced APMs meet certain criteria

As defined by MACRA, Advanced APMs **must meet the following criteria**:

- ✓ **Certified EHR technology**.
- ✓ **Bases payment on quality** measures comparable to those in the MIPS quality performance category.
- ✓ The APM either: **(1)** requires APM Entities to bear more than nominal **financial risk** for monetary losses; **OR (2)** is a **Medical Home Model expanded** under CMMI authority.

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What is an Alternative Payment Model (APM)?

APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value.**

As defined by MACRA, **APMs include:**

- ✓ **CMS Innovation Center model** (under section 1115A, other than a Health Care Innovation Award)
- ✓ **MSSP** (Medicare Shared Savings Program)
- ✓ **Demonstration** under the Health Care Quality Demonstration Program
- ✓ **Demonstration** required by federal law

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PROPOSED RULE
Medical Home Models

Medical Home Models:

- ✓ Have a **unique financial risk criterion** for becoming an Advanced APM.
- ✓ Enable participants (who are not excluded from MIPS) to receive the **maximum score in the MIPS CPIA category.**

A **Medical Home Model is an APM** that has the following features:

- ✓ Participants include **primary care practices** or multispecialty practices that include primary care physicians and practitioners and offer primary care services.
- ✓ **Empanelment of each patient** to a 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 across the medical neighborhood.
  - Patient and caregiver engagement.
  - Shared decision-making.
  - Payment arrangements in addition to, or substituting for, fee-for-service payments.

Advanced APMs 2017

- If you receive 25% of Medicare payments or see 20% of your Medicare patients through an Advanced APM in 2017, you earn a 5% incentive payment in 2019.
  - Comprehensive ESRD Care Model (Two-Sided Risk Arrangement)
  - Comprehensive Primary Care Plus (CPC+)
  - Shared Savings Program – Tracks 2 & 3
  - Next Generation ACO Model
  - Oncology Care Model (Two-Sided Risk Arrangement)
    - Final list January 1, 2017

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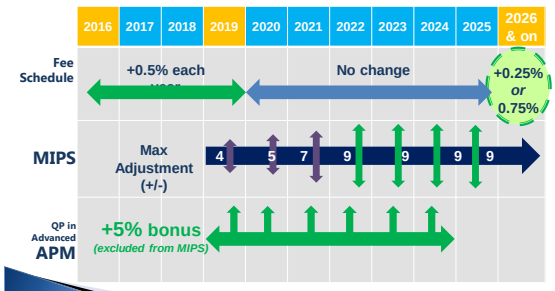
MIPS adjustments and APM Incentive Payments begin 2019



Take Away Points

- MACRA changes the way Medicare Part B pays clinicians and offers incentives for providing high value care
- The Quality Payment Program includes two pathways (MIPS or APM)
- Clinicians are excluded if they are in 1st year Part B participation, have a low volume of patients, or participate in Advanced APM
- Payment adjustments and bonuses begin in 2019 based on 2017 performance
- CMA and AMA actively involved with CMS

"PICK YOUR PACE"

MACRA FLEXIBILITY Announced "Pick Your Pace"

- Clinicians pick their pace for the first year – both in how they participate and when.
  - Avoid payment adjustments 2019 payment year
  - Don't Participate= 4 percent payment adjustment
- Four options described in final rule:
  - Plenty of questions unanswered
  - How will the program maintain budget neutrality?
- Stay Connected
  - https://blog.cms.gov/2016/09/08/qualitypaymentprogram-pickyourpace

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First Year Participation Option 1

- Submit Something

Test Participation

- Choose any point in the 2017 calendar year to begin.
- As long as you submit a minimum standard to Medicare, you will avoid a negative payment adjustment.
- This option is designed to help test systems and prepare for broader participation in 2018 and 2019.

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First Year Participation Option 2

Partial Participation

- Choose to participate for part of the 2017 calendar year.
- Potentially still qualify for a bonus.

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First Year Participation Option 3

Full Participation

- Participate for a full year (beginning January 1, 2017)
- Qualify for a positive payment adjustment
- Clinician practices of all sizes can successfully submit a full year's quality data

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First Year Participation Option 4

Advanced APMs

- Choose to join or stay in an Advanced Alternative Payment Model (Advanced APM) in 2017
- Potentially qualify for a 5 percent bonus
- The Quality Payment Program **does NOT** change how any particular APM functions or rewards value. Instead, it **creates extra incentives** for APM participation

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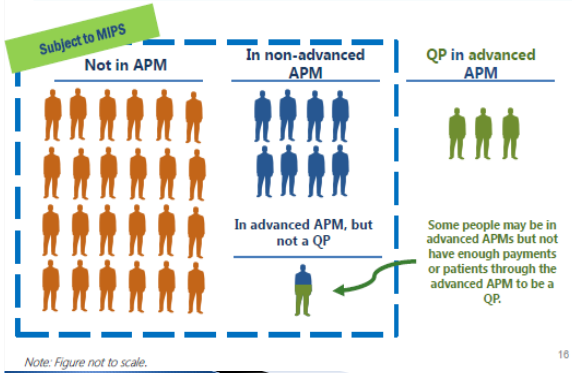
Note: Most clinicians will be subject to MIPS.



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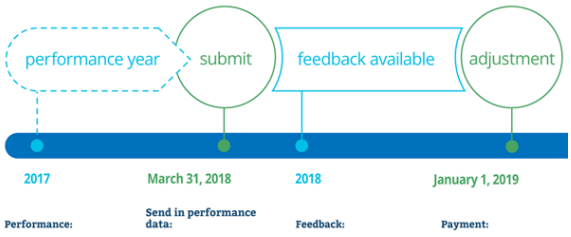
The Timeline for the Quality Payment Program



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The Timeline for the Quality Payment Program

When does the Quality Payment Program start?

You get to pick your pace for the Quality Payment Program. If you're ready, you can begin January 1, 2017 and start collecting your performance data. If you're not ready on January 1, you can choose to start anytime between January 1 and October 2, 2017. Whenever you choose to start, you'll need to send in your performance data by March 31, 2018.

The first payment adjustments based on performance go into effect on January 1, 2019.

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PREPARING YOUR PRACTICE FOR MACRA

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Preparing your practice for MACRA

- Learn about MACRA and decide if an APM is right for your practice. Otherwise, you will be in MIPS
- Participate in 2016 Quality Reporting
- Avoid 2018 payment adjustment penalties
- Review MIPS quality measures and reporting mechanisms
- Contact your EHR vendor
- Explore the list of clinical practice improvement activities

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Preparing your practice for MACRA

Getting ready for MIPS.

Should I participate in MIPS as an individual or a group?

Reporting as an individual.

If you send MIPS data in as an individual, your payment adjustment will be based on your performance. An individual is defined as a single National Provider Identifier (NPI) tied to a single Tax Identification Number.

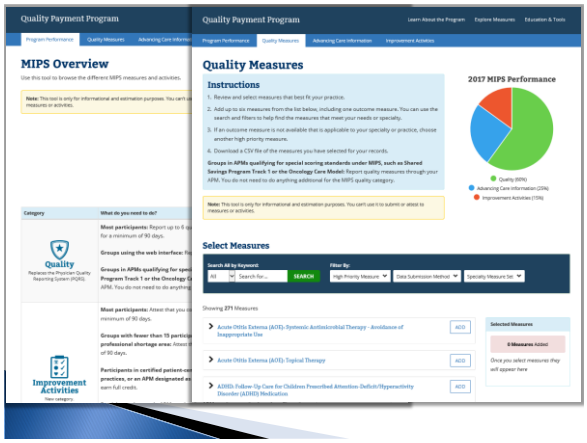
You'll send your individual data for each of the MIPS categories through an electronic health record, registry, or a qualified clinical data registry. You may also send in quality data through your routine Medicare claims process.

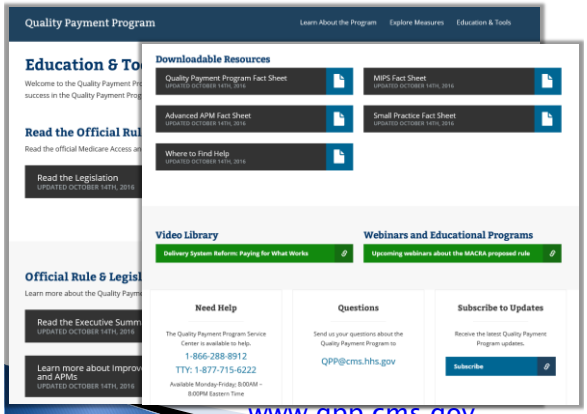
Reporting as a group.

If you send your MIPS data with a group, the group will get one payment adjustment based on the group's performance. A group is defined as a set of clinicians (identified by their NPIs) sharing a common Tax Identification Number, no matter the specialty or practice site.

Your group will send in group-level data for each of the MIPS categories through the CMS web interface or an electronic health record, registry, or a qualified clinical data registry. To submit data through our CMS web interface, you must register as a group by June 30, 2017.

www.qpp.cms.gov NEW





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Easier Access for Small Practices

- "Flexibilities and Support for Small Practices
  - Fact Sheet
    - https://qpp.cms.gov/docs/QPP_Small_Practice.pdf
- $20 million/yr 2016-2020 to help small/rural practices
- **CMA Resource Center**
  - http://www.cmanet.org/resource-library/detail/?item=macra-what-should-i-do-now-to-prepare-a
- CMS Education Materials
  - www.qpp.cms.gov
  - https://qpp.cms.gov/docs/Quality_Payment_Program_Overview_Fact_Sheet.pdf

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PQRS AND EHR QUALITY REPORTING

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2016 Physician Quality Reporting System (PQRS)

- Report quality measures in 2016
  - Avoid 2.0% PQRS payment reduction in 2018
- Groups of 10 or more providers
  - Receive additional 4% VBM payment reduction
- Solo practitioners and groups of 2-9
  - Receive additional 2% VBM payment reduction
- 2018 last PQRS payment adjustment issued
  - Starting 2019 adjustment for quality reporting made under MIPS

How Many Quality Measures in 2016?

- Report at least 9 measures.
- Report at least 50% of applicable patients for each measure for the full year.
- Measures should cover at least 3 National Quality Strategy domains.
- Report at least 1 "cross-cutting measure" (only those who see patients face-to-face)

2015 PQRS and QRUR Feedback Reports

- EPs who did not satisfactorily report PQRS 2015
  - Payment adjustment letters are currently being mailed.
  - Payment Adjustment -2% in 2017
  - Individual or Group NPI/TIN
- Request Informal Review by November 30th
  - https://www.qualitynet.org/portal/server.pt/community/pqri_home/212
- PQRS Feedback Reports program year 2015
  - https://portal.cms.gov.
  - Access via Enterprise Identity Management (EIDM) Acct
- No hardship exemptions

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EHR Payment Adjustment (PA) Meaningful Use

- EPs not successfully demonstrating "meaningful use" of certified EHR technology
- Payment adjustments:
  - 2017 97% (3% Based on payment year 2015)
  - 2018 96%
  - 2019 Advancing Care under MIPs program penalties
- PQRS, VM and EHR-MU ends Dec. 31, 2018

2016 first time participant Attestation period to avoid the 2017 payment adjustment	July 4, 2016 – October 1, 2016

EHR Meaningful Use 2016

- EPs new to the program in 2016
  - Reporting period = any continuous 90-day period
  - Attest by 10/1Avoid adjustment 2017
  - Attest by February 28, 2017 avoid adjustment 2018
- All returning participants
  - Reporting period = entire calendar year 1/1-12/31
  - Attest by February 28, 2017 avoid adjustment
- User Guide: (Basics, MU, Attestation Checklist)
  - https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/beginners_guide.pdf

MACRA Compared to Current Law: Bonuses, Penalties & Payment Updates

California Medical Association

Year	BONUS (excludes Exceptional Bonus)			PENALTIES			FEE SCHEDULE INCREASES (regardless of performance)		
	Current	MACRA MIPS*	MACRA QAPMs	Current	MACRA MIPS*	MACRA QAPMs	Current	MACRA MIPS	MACRA APMs
2015	0	N/A	N/A	-4.5%	N/A	N/A	-21% under SGR	N/A	N/A
2016	0	N/A	N/A	-6%	N/A	N/A	0%	+0.5%	+0.5%
2017	0	N/A	N/A	-9%	0%	0%	0%	+0.5%	+0.5%
2018	0	N/A	N/A	-10%	0%	0%	0%	+0.5%	+0.5%
2019	0	+4%	+5%	-11% or more	0%*	0%*	0%	+0.5%	+0.5%
2020	0	+5%	+5%	-11% or more	-5%	0%	0%	0%	5%
2021	0	+7%	+5%	-11% or more	-7%	0%	0%	0%	5%
2022	0	+9%	+5%	-11% or more	-9%	0%	0%	0%	5%
2023	0	+9%	+5%	-11% or more	-9%	0%	0%	0%	5%
2024	0	+9%	+5%	-11% or more	-9%	0%	0%	0%	5%
2025	0	+9%	+5%	-11% or more	-9%	0%	0%	0%	5%
2026 +	0	+9%	0%	-11% or more	-9%	0%	0%	+0.25%	+5.75%

* CMS will not impose penalties for the 2017 performance reporting period for physicians who report for one patient on one quality measure, one improvement activity, or the four required EHR Advancing Care Information measures. However, physicians who choose not to report any performance data will be subject to a 4% penalty.

Who to Call for Assistance

- **Quality Net Help Desk**
  - Registration questions or login issues
  - Portal password issues
  - Program and measure-specific questions
- **Qnetsupport@hcqis.org**
  - 866-288-8912 (7:00am-7:00pm CST M-F)
  - Provide name, practice, address, phone/email
- **VM Help Desk** (8:00am-8:00pm EST M-F)
- • 888-734-6433 Option 3 or pvhelpdesk@cms.hhs.gov
- **EHR Incentive Information Center**
  - 888-734-6433

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MLN Connects™ Weekly Provider e-News

- Weekly CMS publication issued every Thursday
  - Policy updates
  - Announcements and other reminders
  - CMS National Provider Calls
  - MLN educational materials
  - Other news and information of interest to health care providers/staff

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive.html

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CMA Reimbursement Helpline

888-401-5911

Email us at economicservices@cmanet.org

Membership line – (800) 786-4262

Cheryl Bradley – (213) 226-0338 or cbradley@cmanet.org

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