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# FIVE ANSWERS TO YOUR MOST IMPORTANT QUESTIONS ABOUT MACRA

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**T**he Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) may be one the first big landmark initiatives pushing clinicians into a new landscape of value-based payment after decades of fee-for-service care, but it's unlikely to be the last. While MACRA's changes will not affect every clinician, it could very well herald a shift that commercial payers may soon begin to follow in droves.

## WHAT IS MACRA?

MACRA is a shift in federal Medicare payments for physicians and other clinicians from volume to value. This shift will now compensate clinicians for not just what they do, but how they do it, through either a scoring system known as the Merit-based Incentive Payment System (MIPS), or Advanced Alternative Payment Model (APM) pathways. These are combined into what's being called the Quality Payment Program (QPP).

The QPP replaces the Sustainable Growth Rate (SGR) formula of physician payment by consolidating existing reporting methods, some of which had begun to shift payments to a focus on value from volume — Meaningful Use of an EHR system; the Physician Quality Reporting System (PQRS); and the Value-based Modifier (VM) — into one com-

posite score totaling 100 points. This score will be compared to a benchmark to determine applicable bonuses or penalties for a given year.

There is also a new performance category, called Improvement Activities (IAs), which will be part of the 100-point scoring system as well. A physician's score in four of the MIPS categories will determine payment bonuses or penalties, starting in 2019 (based on 2017 data).

## WHAT ARE MIPS AND ADVANCED APMs?

Clinicians will have two payment pathways: MIPS or Advanced APMs. "MIPS is nothing more than a scorecard of how you're doing," Steve Gordon, a physician and national principal healthcare consultant with Point B, a management consulting company, says. Most clinicians will qualify for MIPS, which breaks down into four categories:

**Quality:** Clinicians choose up to six quality measures to report to CMS that best reflect their practice. They must include an outcome measure or a high-priority measure, and one cross-cutting measure. This category counts for 60 percent of the score for the first year of reporting.

**Improvement Activities:** Most clinicians can attest they completed four (or two for small or rural health providers or those in health shortage areas)

improvement activities from a list of approximately 90, as long as they are most relevant to their practice. A few examples of improvement activities are in categories such as expanded practice access or through better beneficiary engagement. Practices recognized as certified medical homes receive full credit in this category, and those in APMs receive at least half credit. This category counts for 15 percent of the score for the first year of reporting.

**Advancing Care Information (ACI):** Here, CMS will primarily be looking for signs the practitioner is focusing on interoperability and information exchange through five required categories (security risk analysis, e-Prescribing, providing patient access, sending summary of care, requesting/accepting summary of care) using certified EHR technology. Thus, clinicians who don't have an optimized EHR system may want to focus their first year on getting their health IT up and running. Clinicians can earn bonus points for meeting additional optional measures. This category counts for 25 percent of the score for the first year of reporting.

**Resource Use:** Clinicians will not be assessed on this factor in 2017, but when they are, CMS will calculate these measures based on claims. There is nothing clinicians have to do here in terms of reporting because it's a score derived from their claims based on factors like generated Medicare costs.

#### **OPTIONS FOR MIPS REPORTING IN THE FIRST YEAR:**

- Don't participate. Clinicians will receive a four percent penalty in 2019.
- Submit just one quality measure, one IA, or minimum ACI submission to be safe from a penalty.
- Submit a partial year of just 90 days of 2017 data and clinicians may qualify for a neutral payment adjustment or up to a maximum bonus.
- Submit one full year's worth of data and clinicians may have more likelihood for a maximum payment bonus.

The good news is that practices need only report on one quality measure, the minimum ACI submission, or a practice improvement activity in the first year to avoid a payment penalty. However, to avoid future penalties and to secure higher bonuses, remember, "You're competing against your peers. If they start doing better, you're going to have to continue to do better," Larry Kocut, physician and principal and national leader of the Center for Healthcare Regulatory Insight, an organization that assesses regulatory and policy trends driving health care transformation, and a former CMS official, points out.

#### **ADVANCED APMs**

Fewer practices will be exempt from MIPS and qualify for the second payment pathway, Advanced APMs, which come with an automatic five percent bonus. However, for those interested in the

Advanced APM pathway, there are several qualifying programs, such as: Medicare Shared Savings accounts track two and three, Next Generation ACOs, Comprehensive ESRD Care (CEC), Comprehensive Primary Care Plus (CPC+) and the Oncology Care Model, to name a few. In order to qualify, an Advanced APM must:

- Bear some financial risk
- Base their payment on quality measures that are comparable to MIPS
- Utilize certified EHR technology

CMS will update the requirements that define Advanced APMs annually and has resources to help practices determine if an APM meets CMS criteria. As part of the QPP, there is the Qualified Participant (QP) concept, which determines whether a clinician who practices within an Advanced APM model is eligible for MACRA's Advanced APM payment pathway. Even if they are not a QP, participating in an Advanced APM will help that practice with MIPS scoring.

#### **WHY SHOULD I CARE?**

MIPS may be a "quantum leap" for small, independent practices, according to David Wildebrandt. However, Wildebrandt, a managing director of

#### **HOW YOUR SCORES AFFECT YOUR PAYMENTS:**

A clinician's MIPS score will not only be based on the performance in their chosen quality measures, but how they compare to other clinicians. This comparison will create a "threshold" score — or a baseline. Starting in 2019, clinicians participating in MIPS will be eligible to receive positive or negative Medicare payment adjustments, starting at four percent and gradually increasing to nine percent in 2022. As noted earlier, clinicians will be able to avoid a penalty in 2019 by submitting one measure.

Medicare Part B payment adjustments will be based on the following:

- Clinicians who score at the threshold will not receive an annual payment adjustment.
- Clinicians with a MIPS score above the threshold will receive a positive payment adjustment two years after the reporting period.
- Clinicians whose MIPS score is below the threshold will receive a negative payment adjustment two years after the reporting period.
- Clinicians whose MIPS score is in the lowest quartile will be adjusted to the maximum negative adjustment two years after the reporting period.

For 2019 through 2024, "exceptional" performers will be eligible for an additional sliding scale positive payment adjustment of up to 10 percent.

healthcare performance improvement for Berkeley Research Group, a global strategic advisory and expert consulting firm to businesses, government agencies and regulatory bodies, sees it as an opportunity for clinicians to integrate value-based care into their practice, which is the direction that CMS has committed to for the future. At the very least, from a financial standpoint, participating in MIPS will keep clinicians from receiving payment penalties. At best, participating will bring a clinician's practice payment incentives and a shift in how they think about patient care. One point to note, if a clinician's practice generates less than \$30,000 per year in Medicare Part B payments or has fewer than 100 unique patients enrolled in the federal program, they are exempt from MIPS, at least for now.

#### **WHAT IS NEW AND DIFFERENT FROM PAST MEDICARE REIMBURSEMENT MODELS?**

MACRA replaces the former Sustainable Growth Rate (SGR) system of Medicare payment, which would have resulted in a steep payment reduction to clinicians, jeopardized clinicians' ability to accept Medicare patients, and even prevented many seniors from accessing care.

"The whole theory behind MACRA is that it better aligns reporting programs and really tries to reduce clinicians' administrative burdens," Kocut says. In its place, MACRA intends to improve upon old programs with new ones in the following ways:

##### **Advancing Care Information (ACI) vs. Meaningful Use:**

The Meaningful Use program was disliked by many clinicians for being one-size-fits all, and had an all-or-nothing reporting approach. ACI seeks to allow for flexible paths to ACI success, allowing clinicians to customize how they use EHRs with fewer included and required measures in ways that are most appropriate for their practice.

**Quality vs. PQRS:** The biggest change from the PQRS program to the Quality portion of MIPS is that there will be fewer measures which clinicians have to pick, going down from nine to six. The measures are also somewhat less prescriptive than they were in PQRS and provide increased focus on registries.

**Value Based Modifier (VM) vs MIPS:** The VM feedback report will be replaced by a MIPS feedback report so clinicians can see their scores and adjust accordingly. Another change is that unlike the VM, where performance scoring is in buckets, scoring in MIPS is linear.

#### **WHAT DO PRACTICES NEED TO KNOW TO SUCCEED IN THIS NEW WORLD?**

- **Choose the right payment track:** It may seem obvious, but the very first place for any practice to start is to determine if it qualifies for MIPS or an Advanced APM. While the decision cannot be

simply made at the start of each year due to the fact CMS will not indicate whether you are a QP until after the start of the MIPS reporting year, there are online tools that will help clinicians determine which is the best path for them. Clinicians will usually be able to determine based on CMS published information if they are participating in one of the CMS-specified Advanced APMs.

- **Check the health of your IT systems:** If a clinician doesn't have an EHR that meets federal certification criteria, now is the time to get one up and running. Kocut recommends practices review existing health IT systems, "to streamline data collection and make sure that their systems are able to generate reports that enable users to assess their MIPS progress." Clinicians must take a look at MIPS-related health IT measures and optimize their EHR system to comply, including their measures around interoperability and patient access. They should work with vendors to enhance the EHR system if necessary to ensure that it meets MACRA needs and applicable product certification requirements.

**Assess current performance:** Point B Consulting's Gordon recommends practices take a look at, "How [you] compare to other practices and what changes can we make to improve [your] performance?" Kocut agrees and pushes practices to "develop processes to better understand their current performance so they can start thinking about strategies for care improvement and educational resources to get physicians up to speed on changes in MIPS." One way to compare is by looking at the MIPS quality benchmarks that CMS will publish at the end of each year. Clinicians can also assess their situation by looking at past performance, especially with regards to how they've done with Meaningful Use and other programs.

**Train or hire new staff:** Only after a practice has made performance assessments and health IT decisions should they hire new staff that might be needed to bridge any gaps.

**Consider outside resources:** "Each practice really needs to tailor its response to its own clinicians," Gordon says. He recommends turning to professional associations, specialty societies, and EHR vendors to ask for help. "I think it's an opportunity for a practice to seek collaboration and guidance."

#### **CONCLUSION:**

Remember, if the coming changes feel overwhelming, CMS has purposefully lowered the reporting requirements for 2017 to only one quality or practice improvement reporting measure or a minimum ACI submission, giving practices time to catch up. However, don't put off getting ready for the QPP; MACRA is here to stay and will benefit those practices that are the most proactive.