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The Healthcare Roundtable

MACRA Update

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MACRA UPDATE

- Regulatory History
- Overview of MACRA and QPP
- Implementation of MACRA
- Impact of MACRA on payment and reimbursement

MACRA REGULATORY HISTORY

The Center for Medicare and Medicaid Services (CMS) finalized the Medicare Quality Payment Program (QPP) created by MACRA which established two (2) tracks for physician payment:

1.Merit-Based Incentive Payment System (MIPS); and

2.Alternative Payment Models (APMs)

Complex legislation released October 2016 by CMS to outline how CMS plans to implement the clinical payment changes to the QPP mandated under the Medicare Access and CHIP Reauthorization Act, of 2015.

WHAT IS MACRA?

MACRA ⇒ Medicare Access and CHIP Reauthorization Act (MACRA)

MACRA will impact clinical payments for the next decade.

MACRA repealed the Sustainable Growth Rate (SGR).

WHAT IS MACRA?

MACRA:

- Locks provider payment rates at near zero growth.
- Establishes two (2) new payment tracks under the QPP:
  - → MIPS
  - → APM

MACRA IMPLEMENTATION

- MACRA start date is: January 1, 2019
- CMS has proposed to use performance data from 2017 to determine payment adjustments in 2019.

WHO IS IMPACTED BY QPP?

Approximately 712,000 clinicians will be affected by QPP changes in the first performance year (2017)

Included payments and clinicians:

- Any service billed under the Medicare Physician Fee Schedule (MPFS). Adjustments will apply to the work, practice expense, and physician liability insurance (malpractice) RVUs.
- Physicians, Physician Assistants (PAs), Clinical Nurse Practitioners (NPs), Nurse Specialists, Certified Registered Nurse Anesthetists (CRNAs), and groups that include any of these clinicians.

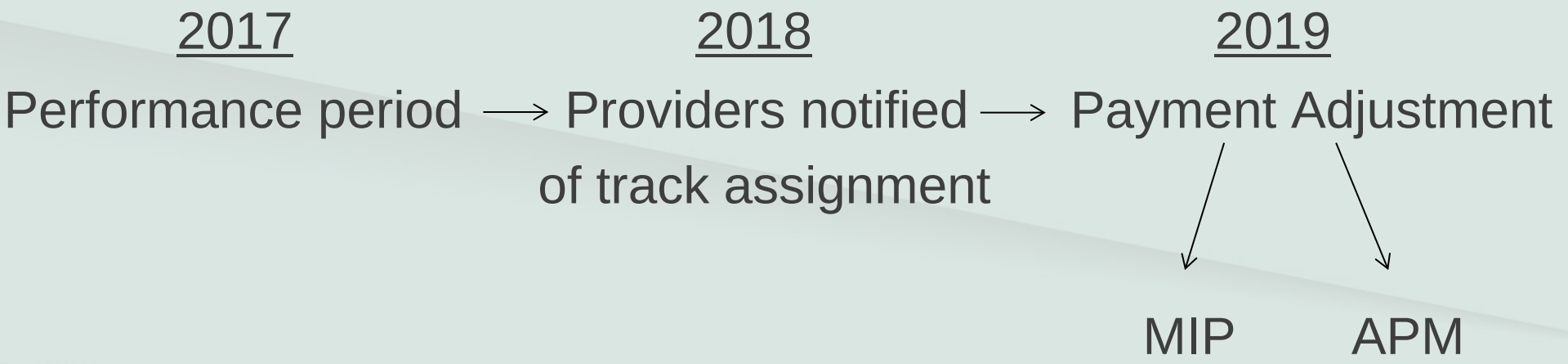
EXEMPT PAYMENTS AND CLINICIANS

- Inpatient Prospective Payment System
- Outpatient Prospective Payment System
- Ambulatory Surgical Center Payment System
- Clinicians or groups that fall under the low volume threshold that CMS defines as clinicians or groups with $30,000 or less in Medicare Charges OR 100 or fewer Medicare patients.
- Clinicians in their first year billing Medicare.

MACRA TIMELINE

- MACRA became effective in April 2015.
- CMS' MACRA proposed rule was released in late April 2016.
- Final rule was released in October 14, 2016.
- Clinical payments will not be impacted by the QPP until January 1, 2019.
- CMS will use 2017 as the performance year for determining clinical payment adjustments in 2019.

MACRA TIMELINE



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IMPACT OF HEALTH CARE REFORM STATUS ON MACRA

These Reasons Why MACRA Will Most Likely Proceed Forward:

- MACRA has strong bipartisan support.
- Delay would be tied to budgetary implications.
- Bending the Medicare Cost Curve is not a partisan issue.

KEY DIFFERENCES BETWEEN MIPS AND AAPM

Two New Payment Tracks for Clinicians.

MIPS: Medicare will consolidate and expand upon all three of clinicians' pay-for-performance programs including:

- Meaningful Use
- Value-based Payment Modifier
- Physician Quality Reporting System

Single revenue-neutral program

* CMS will score clinicians and groups on their performance in four (4) categories:
  - Quality
  - Cost
  - Improvement Activities (IA)
  - Advancing Care Information (ACI)

MIPS

* Starting in 2019 ⟶ Physicians in this track will face a range of payment adjustments starting with a potential penalty of -4% and bonuses as high as 12% in 2019.

* These penalties and bonuses will grow to payment reductions as much as 9% and increases of up to 27% after the first few years of the program.

APM

* Clinicians or groups who qualify for the Advanced APM payment track can earn favorable financial rewards.
* Only clinicians or groups who are part of risk-based payment models will qualify.
* Incentivizes a shift toward risk.
* Clinicians or groups that participate in Advanced APM, as defined by CMS, and are able to convert a large enough share of their Medicare and/or other payer reimbursement to risk-based payment models, will earn a 5% annual payment bump from 2019-2024 and they will be exempt from the MIPS requirements.

DO CLINICIANS GET TO CHOOSE WHICH TRACK THEY WANT TO BE ON?

YES **and** **NO**

APM entities can choose to enter into Advanced APMs and strategically increase the amount of traditional Medicare payments or patient counts ties to those Advanced APM models.

↓

Clinicians or groups in those APMs can qualify for the Advanced APM track (AAPM) instead of the MIPS.

* However → clinicians that already meet the criteria to qualify for the AAPM track with their traditional Medicare book of business *cannot* opt out of the AAPM track and into the MIPS track.

IS THERE A THIRD OPTION BETWEEN MIPS AND THE AAPM TRACKS?

YES

APM entities that participate in Advanced APM models, but have less than the required percentage of revenue at risk, can fall into a category that is straddling the line between the APM and the MIPS track:

Partial Qualifying APM Participants

*There are revenue and patient count at risk requirements for this category.

Clinicians and Groups ⟶ at least 20% (but less than 25%) of their Medicare payments tied to an Eligible APM in 2019, then at least 40% (but less than 50%) in 2021, and at least 50% (but less than 75%) in 2023.

THIRD OPTION → PARTIAL QUALIFYING APMs

- Partial Qualifying APMs still do not qualify for the AAPM track and the associated 5% bonus, however, they can choose whether or not to participate in the MIPS payment track.
- If opting into the MIPS track, clinicians and groups will be scored and assigned a payment adjustment alongside all other MIPS participants.
- If opting out of the MIPS track, clinicians and groups will not receive any payment adjustments for that performance year.

QUALIFICATION IS RESET EACH YEAR

- Each year, clinicians and groups will have a new opportunity to qualify for the AAPM track.

- Those clinicians and groups who do not qualify for the AAPM track will automatically be assigned into the MIPS track *unless* they are below the low volume threshold or are in their first year accepting Medicare patients.

CMS PREDICTION

Based upon CMS' calculations:

- 83% - 90% of eligible clinicians will fall into the MIPS track in 2017.
- 10% - 17% of clinicians will fall into the AAPM track.

MIPS TRACK

Clinicians scored based upon their performance across four (4) key categories:

1.Quality

2.Cost

3.Improvement Activities

4.Advancing Care Information

2019 ⟶ Relative weights of each category will equal:

Quality: 60%

Cost: 0%

Improvement Activities: 15%

Advancing Care Information: 25%

From 2021 on ⟶ Quality: 30%

Cost: 30%

Improvement Activities: 15%

Advancing Care Information: 25%

MIPS REPORTING

Under MIPS → clinicians can submit performance data as an:

- individual;
- A group; or
- An APM entity

*Must report the same way across all four (4) categories.

*Currently, CMS does not include Part D drug costs in the proposed assessment of a clinician's resource use and only includes Part A and Part B.

- Medicare Part D should be included "as appropriate and as feasible and applicable."

CMS WILL USE CLINICAL PERFORMANCE UNDER MIPS TO DETERMINE CLINICAL PAYMENT ADJUSTMENTS

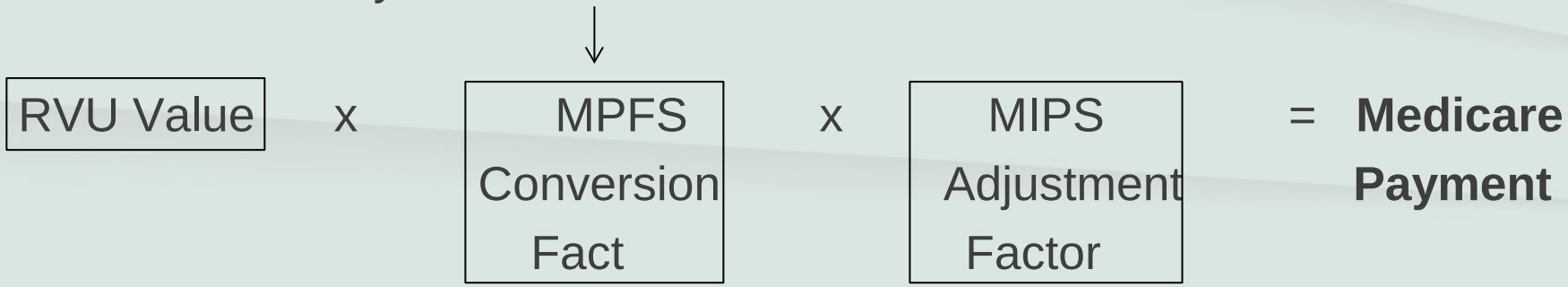
CMS will translate a clinician's/group's/APM entity's performance score into a payment adjustment using the following three-step process:

1. Clinicians/groups/APM entities will be assigned a performance score of 0-100.
2. That score will be compared to the Performance Threshold (PT). The PT will be the means or the median, as selected by CMS, of the composite performance scores for all MIPS participants.
3. Clinicians/groups/APM entities that fall above the PT will receive bonuses, and clinicians that fall below the PT will face penalties.

ANNUAL ADJUSTMENT BASED UPON THE MPFS IS IMPACTED BY QPP

- RVUs
- Conversion Factor
- Payment adjustments under MIPS

Medicare Payment Calculation



HIGH PERFORMERS UNDER MIPS TRACK ELIGIBLE FOR EXTRA BONUS

- CMS set aside a pool of $500 million for the first six years of the program.
- CMS proposes to set an additional performance threshold for exceptional performers at the 25th percentile of the range of possible composite performance scores (CPS) above the normal performance threshold.
- Bonus is determined on a linear sliding scale.

THREE REPORTING OPTIONS IN 2017

1. Minimal Reporting to Avoid Penalties
- Submit any single metric under quality or clinical improvement or the required ACI measures.
- No minimum time period required.
- Will avoid a negative payment adjustment.

2. Reporting Partial Data, Potential for Small Bonus
- Submit more than one quality or clinical improvement metric or more than the required ACI measures
- Must report for a full 90 day continuous reporting period
- Possibility of qualifying for positive payment adjustment, but likely to be small.

3. Report Full Data for Chance of Larger Bonus
- Submit all required data in all categories.
- Must report for a full 90 day continuous reporting period.
- Potential for full payment adjustment. Highest performances still earn additional positive adjustment.

DIFFERENT MIPS REPORTING REQUIREMENTS FOR PATIENT-FACING VERSUS NON-PATIENT-FACING CLINICIANS

- CMS considered non-patient-facing clinicians → radiologists, anesthesiologists, and pathologists

CMS defined non-patient-facing clinicians as any clinician or group that performs fewer than 25 patient-facing services per year.

CMS developed different MIP reporting requirements for non-patient-facing clinicians:

Quality → CMS eliminated the requirement to report one "cross-cutting measure" for all clinicians.

Cost → Starting in 2018 performance year, the cost category will be weighted at 10%.

Advancing Care Information → ACI category is re-weighted to zero.

Improvement Activities → Only required to report one high-weighted or two medium-weighted improved activities.

DIFFERENT MIPS REPORTING REQUIREMENTS FOR HOSPITAL-BASED PROVIDERS

- CMS defines hospital-based clinicians as a MIPS eligible clinician who furnishes 75% or more of their covered professional services in:
  - POS 21 (inpatient hospital)
  - POS 22 (on campus outpatient hospital)
  - POS 23 (emergency room)

* ACI performance category will be reweighted to zero for hospital-based clinicians if they report individually.

MEDICARE QUALITY PAYMENT PROGRAM: CHANGING LANDSCAPE

QPP SUMMARY:

- Majority of physician practices will participate in MIPS in 2017.
- CMS estimates 25% of clinicians will participate in Advanced APMs by 2018.
- In 2019 → Medicare physician payments will be increased or decreased based on MIPS performance data from 2017.
- 2017 is a transition year from the current federal quality reporting programs (PQRS, Meaningful Use) to MIPS.
- Predicted that only physician practices that will experience a 4% penalty in 2019 are those who choose not to report any performance data.

NEXT STEPS TO CONSIDER

- Assess Performance Under Current Programs.
- Review Internal Processes Related to Patient Engagement and Data Exchange.
- Consider which QPP track is best suited for the clinicians or group.
- Evaluate EHR and Other Vendor Readiness and Costs.
- Explore Applicable Measures and Improvement Activities.
- Avoid a 4% Payment Penalty in 2019 by submitting one or more qualifying measures in 2017.
- Complete the details for the MIPS Participation Plan.

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