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FAST BREAK:

MACRA

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Agenda

- MACRA Basics – the Quality Payment Program
- Conflicts between Care Coordination and Fraud & Abuse Compliance ?
- Acquisition of Physician Practices and Further Consolidation
- Practice Management Strategies

MACRA Basics

The Quality Payment Program has two tracks:

- The Merit-based Incentive Payment System (MIPS); OR
- Advanced Alternative Payment Models (APMs)

MACRA: MIPS Basics

- MIPS adds a new performance category of clinical practice improvement activities and consolidates CMS' existing programs:
  - EHR Incentive Programs
  - Value-Based Payment Modifier
  - Physician Quality Reporting System
- Opportunity for +/- 4% payment adjustment (or neutral payment adjustment) potential in 2019 based on 2017 performance.
- MIPS eligible clinicians with scores above the performance threshold CMS sets will receive an additional bonus for exceptional performance (potentially up to 12%).

MACRA Basics: MIPS Performance Categories

- **Quality**
  - For 2017, must report at least 6 measures including 1 outcome measure OR one specialty-specific measure set or measure set defined at subspecialty level, if applicable
- **Cost**
  - 0% weight in 2017 so no action necessary
- **Advancing Care Information**
  - 90-day reporting period
  - Only requires reporting of 4 measures for modified State 2 equivalent or 5 Measures for Stage 3 Equivalent
  - Reporting on Clinical Decision Support and Computerized Order Entry Measures is no longer required
- **Clinical Practice Improvement Activities**
  - MIPS Eligible Clinicians or Groups must perform improvement activities for at least 90 consecutive days during the performance period.
  - To obtain the highest potential score, must perform
    - 2 high-weighted improvement activities
    - 4 medium-weighted improvement activities; OR
    - Some combination of high and medium-weighted activities to obtain 40 points.

MACRA Basics: What's New in MIPS?

- **Advancing Care Information (i.e., Meaningful Use)**
  - No longer "all-or-nothing" to demonstrate meaningful use – MIPS EPs can receive partial credit.
  - Only requires reporting of 4 measures for modified State 2 equivalent or 5 Measures for Stage 3 Equivalent
  - Reporting on Clinical Decision Support and Computerized Order Entry Measures no longer required
- **Clinical Practice Improvement Activities**
  - CMS will offer 90 activities across nine categories (but some are weighted higher than others)
    - Expanded Practice Access Population Management
    - Care Coordination
    - Beneficiary Engagement
    - Patient Safety and Practice Assessment
    - Achieving Health Equity
    - Emergency Preparedness and Response

MACRA Basics

- **MIPS Performance Category Weighting**
  - Quality (60% in 2017, 50% in 2018 and 30% in 2019 on)
  - Cost (0% for 2017, 10% in 2018, 30% from 2019 on)
  - Clinical Practice Improvement Activities – (15%)
  - Advancing Care Information (25%)
- **MIPS Eligible Clinicians**
  - Physician
  - Physician Assistant
  - Nurse Practitioner
  - Clinical Nurse Specialist
  - Certified Registered Nurse Anesthetist
  - Groups that include any of the above professionals

MACRA Basics: How Do Individual MIPS Clinicians Report?

Performance category	Individual Reporting Data Submission Mechanism
Quality	• Claims • Qualified Clinical Data Registry (QCDR) • Qualified Registry • EHR
Cost	• Administrative Claims (no submission required)
Advancing Care Information	• Attestation • QCDR • Qualified Registry • EHR
Clinical Practice Improvement Activities	• Attestation • QCDR • Qualified Registry • EHR

MACRA Basics: How Do Groups Report?

Performance category	Group Practice Reporting Data Submission Mechanism
Quality	• QCDR • Qualified Registry • EHR • CMS Web Interface (Groups of 25 or more) • CMS-approved CAHPS Survey Vendor for MIPS (has to be reported in conjunction with another data submission mechanism) • Administrative Claims (all-cause hospital readmissions measure – no submission required)
Cost	• Administrative Claims (no submission required)
Advancing Care Information	• Attestation • QCDR • Qualified Registry • EHR • CMS Web Interface (Groups of 25 or more)
Clinical Practice Improvement Activities	• Attestation • QCDR • Qualified Registry • EHR • CMS Web Interface (Groups of 25 or More)

MACRA Basics: 2017 Transition Year

- **2017 Transition Year Reporting – "Go At Your Own Pace"**
  - CMS is only requiring submission of limited data in the 2017 performance year to avoid a negative payment adjustment in 2019.
    - A final score of only 3 points totaled across the quality, advancing care information, and clinical practice improvement activities will result in a neutral (zero percent) payment adjustment.
    - Higher scores are likely to result in positive adjustments (up to 4%)
    - Exceptional Performance (e.g., score of 70 points or more) could result in incentive payments for exceptional performance (potentially up to 12%).
  - **Now is the best time to enhance payment for those MIPS Eligible Clinicians or Groups that can perform well in 2017 and subsequent years**

MACRA Basics: Quality Payment Program APMs

- **Advanced APMs in Performance Year 2017 for 2019 Payment Adjustment**
  - Comprehensive ESRD Care (CEC) Model (Large Dialysis Organization)
  - Comprehensive ESRD Care (CEC) Model (non-Large Dialysis Organization with two-sided risk)
  - Comprehensive Primary Care Plus (CPC+) Model
  - Medicare Shared Savings Program – Track 2
  - Medicare Shared Savings Program – Track 3
  - Next Generation ACO Model
  - Oncology Care Model (two-sided risk arrangement)
- **Potential Advanced APMs in Future Years**
  - Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT Track)
  - Advancing Care Coordination through Episode Payment Models Track 2 (non-CERHT track)
  - Cardiac Rehabilitation Incentive Payment Model
  - Comprehensive Care for Joint Replacement (CEHRT Track)
  - Medicare ACO Track 1+
  - Medicare Diabetes Prevention Program

MACRA Basics: APMs

- **How Do You Become a Qualifying APM Participant in 2017?**
  - Receive 25% of your Medicare payments through an Advanced APM, or
  - See 25% of your Medicare Patients through an Advanced APM
- **Qualifying APM Participants will receive a 5% lump sum incentive payment in 2019 if they meet ONE of the above criteria.**
- **Aren't sure whether you will meet the qualifying APM participant criteria?**
  - MACRA allows clinicians to submit for MIPS as a fallback option
  - Play it Safe: Aim for Qualifying APM Participant but also report under MIPS just in case.
- **CMS announced a pilot beginning in 2017 where APM participants will be at lowest risk of pre-payment and post-payment audits by RACs and MACs – another potential benefit**

Conflicts between Care Coordination and Fraud & Abuse Compliance?

- The Stark Law and Anti-Kickback Statute are aimed at reducing risk of overutilization, increased program costs, and corruption of medical decision making– the same goals as APMs.
- "Not determined…in a manner that takes into account volume or **value** of any referrals…"
  - But…the underlying premise of APMs is to pay based on the **value** of care provided.
  - APMs also aim to hold providers accountable for utilization of services to reduce overutilization (e.g., ACOs, Bundled Payments) by taking into account the **volume** of care.
- Are the Stark Law and Anti-Kickback Statute still a necessary safeguard for APM participants?

Conflicts between Care Coordination and Fraud & Abuse Compliance?

- Improving Care Coordination as Beneficiary Inducement?
  - Patient Transportation
  - Providing free technology to patients for medical monitoring
  - Other supplemental services
- Advanced APMs provide opportunities for waivers but gray areas exist…so be cautious

Conflicts between Care Coordination and Fraud & Abuse Compliance?

- Compensation Arrangement requirements may serve as a barrier to coordinated care efforts.
- Fair market value requirements favor valuations based on time and resources, not outcomes.

Acquisition of Physician Practices and Further Consolidation

- Success in MIPS and APMs requires additional administrative efforts on the parts of clinicians and their practices.
- Need strong management AND clinician involvement.
- Driver for further consolidation?

Acquisition of Physician Practices and Further Consolidation

- So you want to partner with or acquire a practice, what should you be looking for during diligence?
  - Unlikely that retrospective analysis will be adequate.
  - Check clinicians' performance on PQRS, meaningful use, and the value-based modifier using CMS public data (e.g., physician compare).

Acquisition of Physician Practices and Further Consolidation

- Penalties Add Up
  - An individual physician or group with less than 10 providers did not report to PQRS in 2015 and did not demonstrate meaningful use.
    - 4% penalty (2% value modifier penalty + 2% PQRS penalty)
    - 2% penalty for not demonstrating meaningful use
    - Cumulative 6% cut to Medicare payments in 2017

Practice Management Strategies

- **How to succeed under the Quality Payment Program?**
  - Employment/Compensation Agreements
    - Employment or Compensation Agreements that are based solely on productivity, work, or collections may not be aligned with what is required for success under MIPS.
    - If CMS is taking a clinician's performance on quality and cost into account in determining their payments, shouldn't their compensation methodology be tweaked?
- **Remember…It's a Budget Neutral System**
  - Poor performers fund the high performers – you want to be in the high performer club.
  - In 2016 under the value modifier, a large proportion did not report at all and will suffer the penalty.
  - Approximately $80 million was shifted from those poor performers to high performers.
  - The relatively small number of high performers results in substantial payment increases for those high performers.

Practice Management Strategies

- **What else should you be doing to perform well?**
  - **Consider strategic relationships with vendors that could assist in improving quality**
    - Look at the quality measures you'll be evaluated on and consider internal changes or vendors that could help you perform well.
      - Would follow-up calls from a care coordinator help improve medication adherence?
      - Would providing patients transportation to appointments (subject to fraud and abuse compliance) prevent a readmission?
      - Would using telehealth (even if you can't bill for it) help improve quality measure performance?
    - **Small changes can have a substantial impact – talk to your staff at all levels.**

Thanks!

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