MACRA – Fall into Place

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About the Presenter

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Introduction

- Love it
- Hate it
- Don’t know a thing about it
What’s the Problem?

- Medicare Trust Fund is running out of money
- SGR from BBA of 97 didn’t work – No one to take care of seniors
- Physicians disgruntled by lack of pay increase
- Americans are unhealthy
- Seniors need healthcare
Problem is complex

- Costliest in the world
- Physicians are not in sustainable supply
- Current rules are massively complicated
- There is no final agreement on how participate in cut costs
What We’re Trying Now

• Give physicians a .5% annual increase until 2019
• Spend less $ on Medicare
  • FFS = physicians are incentivized to provide more services?
    • ↓ Healthcare demand by ↑ the health of the population
      • Implement best practices for preventing costly diagnoses
    • Increase provider supply by:
      • Creating a model of collaboration
      • Patient satisfaction
So What’s the problem with that?

- Regulations that distract from patient care
  - Time consuming, expensive, confusing
- Misrepresentation on the words “value” and “quality”
  - “Value” is defined by a set of statistical metrics and keeping costs down
    - Example: “valuable” pediatrician orders a child’s flu shot.
      - No quality measure for the child’s autism, the reason for the visit.
Complications

- Disincentives to physician autonomy, innovation, & risk-taking
  - Malpractice
  - Physicians shoulder responsibility with control
  - Patient non-compliance and cherry picking
Concerns

• Devaluation of the work provided by a physician
  • There are no academic, physical, or mental concessions to excellence
  • 20 years full time work to become a physician
  • Many are extraordinarily unhappy

• No one knows if it will work
  • 75% of the pioneer ACOs produced no savings or lost money.
The passing of MACRA was met with bipartisan support
MACRA has not “simplified” rules
Experts generally agree - good or bad - it is here to stay

So what is MACRA?
Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)

- Reauthorized Children’s Health Insurance Program (CHIP) for 2 years
- Replaced the SRG
- Combines P4P and Health IT
  - PQRS
  - VM
  - MU
1. Merit-Based Incentive Payment System (MIPS)
2. Alternative Payment Model (APM) program
Does this Affect “YOU”?

This only affects you if you are a:

- Certified Registered Nurse Anesthetists (CRNA)
- Clinical Nurse Specialists (CNS)
- Doctors of Chiropractic (DC)
- Doctors of Dental Medicine (DMD)
- Doctors of Dental Surgery (DDS)
- Doctors of Medicine (MD)
- Doctors of Optometry (OD)
- Doctors of Osteopathy (DO)
- Doctors of Podiatric Medicine (DPM)
- Nurse Practitioners (NP)
- Physician Assistants (PA)
Eligible Providers (AKA EC)

• If you answer “yes” to any below you are NOT eligible.
  • Are you a Medicare Freshman in your very first year billing Medicare?
  • Are you billing less than $30,000 in Medicare Part B allowable charges?
  • Do you see fewer than 101 Medicare patients per year?
#s in 2017

- Excluded, 738K, 55%
- Medicare, 25%
- Medicaid, 21%
- Commercial, 41%
- MIPS, 480K, 9%
- Out of Pocket, 13%
How are Eligible Providers Affected?

- Marketing – CMS Physician Compare Website publishes MIPS Scores
- Future options to join a new group
- Implementation Cost
  - Cost could be greater than penalties
  - Participating with Medicare
  - Commercial payer contracts tied to Medicare
- Payment Adjustments…
2019 Payment Adjustments

• Part B Adjustments
  • MIPS
    • Do nothing in MIPS 2017 you will receive a -4% payment adjustment.
    • Do a little and avoid a payment adjustment
    • +4% for providers in the middle
    • Up to +12% (Exceptional performer will receive up 22%)
  • APM could get 5% lump sum bonus in exchange for taking risk up to 8%
Timing

- Performance year: 2017
- Submit: March 31, 2018
- Feedback available: 2018
- Adjustment: January 1, 2019
What are the current models?

- US healthcare payment models include:
  - Fee-for-Service (MIPS blend)
  - Capitation
  - Alternate Payment Models (APM)
Incentives and downside risk to cost
  - Pay-for-Performance
  - Bundled Payment
  - Shared Savings Programs
  - ACO
  - Patient Centered Medical Homes
(A) APMS
Advanced APMs: https://qpp.cms.gov/

- Can earn a 5% lump sum bonus if they “qualify”
- Use CEHRT
- $ on Quality
- Accept Risk
Downside Risk

- Advanced APM agrees to revenues and expenses in advance
- If you don’t hit the goal:
  - Advanced APM:
    - withholding provider payments,
    - reducing provider rates, or
    - paying CMS back.
- Review data by actuary
You must be eligible as a group:

- An eligible group has 4 identifiers
  - APM identifier (Model)
  - APM Entity identifier (Payer)
  - Taxpayer Identification Number (Group)
  - National Provider Identifier (Provider)
You must be eligible to participate as a provider:

- Contracted with a Qualified Advanced APM model.
  - Some APM models use “Affiliated Practitioners”
  - Most providers are “Participating Providers”
    - List of providers is shared with CMS
    - Providers can participate with multiple APMs
Your patients (tracked for cost) must be eligible:

• Not enrolled in HCC MA or a Medicare cost plan
• Do not have MSP
• Are enrolled in both parts A and B
• Are at least 18 years of age
• Are a USA resident
• Has a minimum of one E/M visit under the rules of the APM.
  • Attributed beneficiaries “belong” to the provider
5% Bonus is Scored at the Entity Level

- Aggregate scores of all EC in an Entity
  - Qualifying APM Participants (QP)
  - Partial qualifying APM Participants (PQP)
    - No bonus but quality to participate in a MIPS APM
- Some exceptions on aggregate Entity level reporting
  - “Affiliated practitioner" list” associated with APM Entity.
  - EC on more than 1 AAPM but does not hit these thresholds by any of them.
Calculating the score for the 5% Bonus

- One or both = QP
  - 25% of Medicare Part B payments
    - must be for “attributed” beneficiaries
  - 20% of Medicare Part B patients
    - are “attributed” beneficiaries
MIPS - Overview

- Participation affects payment in 2019
- “Transition year” (2017/2019) scores are weighted by:
  - Quality: 60%
  - Improvement Activities: 15%
  - Advancing Care Information: 25%
- Budget Neutral
“Pick Your Pace”

- Do nothing  = -4%
- Test = neutral
- Partial = a little
- Full = Up to +12% and more (up to 22%)
Individual versus Group Reporting

- **Individual Reporting Options**
  - Claims
  - Qualified Clinical Data Registry (QCDR)
  - CMS Approved Qualified Medical Registry
  - Approved Electronic Health Records (EHR)
  - The ACI and IA Categories Include Attestation Options

- **Group Reporting Options**
  - Qualified Clinical Data Registry (QCDR)
  - CMS Approved Qualified Medical Registry
  - Approved Electronic Health Records (EHR)
  - The ACI and IA Categories Include Attestation Options
  - CMS Web Interface- (Group of 25 or more)
Quality - 60%
• Replaces the Physician Quality Reporting System (PQRS)
• Highest weighted category = 60% of the MIPS Final Score
• 271 measures to choose to report from
  • There are 168 “High Priority” measures.
• The highest scores require at least:
  • 6 measures including
    • at least 1 Outcome measures or High priority measures
    • Specialty Sets
• **Measures quantify:**
  • Recommended healthcare processes
  • Patient outcomes,
    • Relate to one or more goals that can effect health care cost.
    • Examples:
      • % pts 86+ years who received a screening colonoscopy
      • % pts 16+ with a dx of COPD who had spirometry results documented
      • % pts 18-85 who had a dx of HTN and whose blood pressure was controlled

• **Review the entire list of quality measures at:**
  • [https://qpp.cms.gov/measures/quality](https://qpp.cms.gov/measures/quality)
Example of a Quality Measure

110: Preventive Care and Screening: Influenza Immunization

Performance Met: G8482 Influenza immunization administered or previously received

Exclusion: G8483 Influenza immunization was not administered for reasons documented by clinician (e.g., patient allergy or other medical reasons, patient declined or other patient reasons, vaccine not available or other system reasons)

Not Met: Performance Met: G8484 Influenza immunization was not administered, reason not given

Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.

G0439, G0438, **99215**, 99512, 99429, 99412, 99411, 99404, 99403, 99402, 99401, 99397, 99396, 99395, 99394, 99393, 99392, 99391, 99387, 99386, 99385, 99384, 99383, 99382, 99381, 99350, 99349, 99348, 99347, 99345, 99344, 99343, 99342, 99341, 99337, 99336, 99335, 99334, 99328, 99327, 99326, 99325, 99324, 99316, 99315, 99310, 99309, 99308, 99307, 99306, 99305, 99304, 99245, 99244, 99243, 99242, 99241, **99214, 99213, 99212**, 99205, 99204, 99203, 99202, 99201, 96161, 96160, 90970, 90969, 90968, 90967, 90966, 90965, 90964, 90963, 90962, 90961, 90960, 90959, 90958, 90957, 90956, 90955, 90954, 90953, 90952, 90951, 90947, 90945
How to Avoid the Payment Penalty

• Report one measure on one pt and get 3 points – avoid the penalty
  • Example:
    • Body Mass Index (BMI) Screening and Follow-Up Plan
    • Influenza Immunization
    • Screening for Clinical Depression and Follow-Up Plan
    • Screening for High Blood Pressure and Follow-Up Documented
    • Tobacco Use: Screening and Cessation Intervention
  • Remittance advice from Medicare code N620
Scoring MIPS Quality

• To earn a higher score:
  • In most cases to qualify 50% of the pt must take part and be reported
    • Each quality score is converted to a 10 point decile scoring system
    • Based on the % successful compliance vs the national benchmark
Tobacco Use: Screening and Cessation Intervention

- 600 office visits out of a total of 800 office visits reported (more than 50%)
  - If performance is met with $\frac{500}{600} = 83.3\%$
  - $\frac{9.4}{60} = \text{Percent of Quality Earned (16\%)}$
  - $16\% \times 60\% \times 100 = \text{MIPS POINTS (9)}$
All-Cause Hospital Readmission

- Practices with 16+ providers and at least 200 eligible cases
  - CMS will calculate from claims data
  - Scores in the same way as the other quality measures from 3-10 points
  - The maximum then increases from 60 to 70 Quality Measure points
BONUS POINTS

- The maximum score cannot exceed 100%
  - 2 points for each additional outcome/patient experience measure
  - 1 point for each additional high-priority measure
  - 1 point for submitting electronically end to end using CEHRT
Advancing Care Info
25%
- ACI is worth 25% of the MIPS Final Score
- Replaces MU
  - Examples:
    - Security Risk Analysis
    - e-Prescribing
    - Provide Patient Access
- Exemptions
  - “Hospital based”
  - “Non-patient facing”
  - PAs, NPs, CRNAs not previously included in Medicare Meaningful Use program
  - Hardship exemptions
ACI Base, Performance, and Bonus Scores

- **Base**
  - 4 or 5 Measures depending on the CEHRT version used
    - all required to get a base score
- **Performance**
  - Different Measures depending on the CEHRT version being used
- **Bonus**
  - If you report to one or more additional registry report options = 5 points
  - Improvement Activities using your Certified EHR, you can earn 10 additional points.
The maximum ACI score is 100 points calculated in three parts.

- EC may earn up to 155%, but capped at 100%
  - Base Score
  - Performance Score
  - Bonus Points

Base Score (50%) + Performance Score (90%) + Bonus Points (15%) = ACI Performance Score.
Example – ACI Score Transition Measures CEHRT 2014

<table>
<thead>
<tr>
<th>MEASURE NAME</th>
<th>REQUIRED BASE</th>
<th>PERFORMANCE SCORE WEIGHT</th>
<th>BONUS</th>
<th>BONUS</th>
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<tbody>
<tr>
<td>Health Information Exchange</td>
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<tr>
<td>Provide Patient Access</td>
<td>BASE</td>
<td>20</td>
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<tr>
<td>e-Prescribing</td>
<td>BASE</td>
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<td></td>
<td></td>
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<tr>
<td>Security Risk Analysis</td>
<td>BASE</td>
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</tr>
<tr>
<td>Immunization Registry Reporting</td>
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<td>10</td>
<td></td>
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<tr>
<td>Medication Reconciliation</td>
<td>No</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient-Specific Education</td>
<td>No</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>No</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>View, Download, or Transmit (VDT)</td>
<td>No</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialized Registry Reporting</td>
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<td>0</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Syndromic Surveillance Reporting</td>
<td>No</td>
<td>0</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>IA CEHRT</td>
<td></td>
<td>10</td>
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</tr>
<tr>
<td></td>
<td>50</td>
<td>90</td>
<td>5</td>
<td>10</td>
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</table>
Example – ACI Score - 2015 Certified

<table>
<thead>
<tr>
<th>MEASURE NAME</th>
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<th>PERFORMANCE SCORE WEIGHT</th>
<th>BONUS</th>
<th>BONUS</th>
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</thead>
<tbody>
<tr>
<td>e-Prescribing</td>
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<td>Security Risk Analysis</td>
<td>BASE</td>
<td>0</td>
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<td></td>
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<tr>
<td>Send a Summary of Care</td>
<td>BASE</td>
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<tr>
<td>Provide Patient Access</td>
<td>BASE</td>
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<td></td>
<td></td>
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<tr>
<td>Request/Accept Summary of Care</td>
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<tr>
<td>Patient-Generated Health Data</td>
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<tr>
<td>Patient-Specific Education</td>
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<td>10</td>
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<td></td>
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<tr>
<td>Secure Messaging</td>
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<td>10</td>
<td></td>
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</tr>
<tr>
<td>View, Download, Transmit</td>
<td>0</td>
<td>10</td>
<td></td>
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</tr>
<tr>
<td>Immunization Reg Reporting</td>
<td>0</td>
<td>10</td>
<td></td>
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<tr>
<td>Medical Info Reconciliation</td>
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<td>10</td>
<td></td>
<td></td>
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<tr>
<td>Clinical Data Registry Reporting</td>
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<tr>
<td>Electronic Case Reporting</td>
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<tr>
<td>Public Health Reg Reporting</td>
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<tr>
<td>Syndromic Surveillance Reporting</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td></td>
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<tr>
<td>IA CEHRT</td>
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</tbody>
</table>

50 90 5 10
Improvement Activities
15%
MIPS - Improvement Activities

- Brand-new category - 15% of final MIPS Score
- 40 points = maximum score
- Automatic full credit to MIPS APMS and Medical Home Models
- Double credit for activities by:
  - Providers in practices with 15 or fewer clinicians
  - Providers in practices located in a rural area
  - Providers in practices located in a geographic Health Professional Shortage Area
  - Non-Patient Facing Providers or Groups
Examples of IA

• **High Weighted**
  • Anticoagulant management improvements
  • Collection and follow-up on patient experience and satisfaction data on beneficiary engagement
  • Glycemic management services

• **Medium Weighted**
  • Care transition documentation practice improvements
  • Collection and use of patient experience and satisfaction data on access
  • Diabetes screening
The Final Score
Considering the Final Score

- Quality, 60%
- ACI, 25%
- IA, 15%
• 90% of eligible clinicians will participate
• Budget Neutral except for $500M for Exceptional Performance
• Estimate is $199M
Calculating the Final Score Under MIPS

- Calculate your Points per Component
- Calculate the % of each Component that was earned
- Convert the % earned to the allowed % per Component
- Sum

<table>
<thead>
<tr>
<th>MIPS Component Categories</th>
<th>MIPS Components Percent</th>
<th>Max Points</th>
<th>ENTER YOUR Actual Points Earned</th>
<th>% of Max Score that was Earned = (Max Points / Actual Points) D/C</th>
<th>Final Score = (MIPS Component % x % of Max Score that was Earned x 100) E x B x 100</th>
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<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
<td>60</td>
<td>3</td>
<td>5%</td>
<td>3</td>
</tr>
<tr>
<td>CAI</td>
<td>25%</td>
<td>100</td>
<td>0</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>IA</td>
<td>15%</td>
<td>40</td>
<td>0</td>
<td>0%</td>
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</tbody>
</table>
Over 70 points is an Exceptional Performance Score

Instructions: Fill in the number of points you earned for each MIPS Component Category

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</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
<td>60</td>
<td>50</td>
<td>83%</td>
<td>50</td>
</tr>
<tr>
<td>ACI</td>
<td>25%</td>
<td>100</td>
<td>60</td>
<td>60%</td>
<td>15</td>
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<tr>
<td>IA</td>
<td>15%</td>
<td>40</td>
<td>30</td>
<td>75%</td>
<td>11</td>
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</tbody>
</table>

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Calculating the Final Score Under MIPS APMs

- Depends on the APM model:
  - Quality (50%), ACI (30%) and IA (20%---full credit is given for IA)
    - Medicare Shared Savings Program Accountable Care Organizations tracks 1-3
    - Next Generation ACO Model
  - Quality (0%) ACI (75%) and IA (25% ---full credit is given for IA)
    - CEC Model (LDO and Non LDO arrangement 1-2 side risk)
    - CPC + Model
    - OCM (1-2 side risk)
    - Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)
What now?

- Understanding what MACRA is and how it works in 2017
- QPP stakes get higher each year
- Ensure correct coding to the highest specificity
- Annual micro training and proficiency verification
- Practice Plan
- Training
It’s going to get tougher

• Stakes get higher each year with harder scoring
• The “Cost” category, which replaces the VM, will begin in 2018
Thank you and CEU

• bb3f