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MANAGEMENT CONSULTING

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WHITE PAPER



## MACRA Prep:

Timeline, Decisions and Planning: What You Need to Know

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## Introduction

Ever since Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA) last year, the healthcare industry has been abuzz with discussions of what it will ultimately mean. This past April, we found out. The Centers for Medicare & Medicaid Services (CMS) released the Notice of Proposed Rulemaking (NPRM) providing the details on how the law will be implemented and the new requirements for healthcare organizations. CMS encouraged stakeholders to submit comments to the proposed rule through June of 2016 and the release of the final regulation is set for November 2016. Measurements will begin in January 2017 and reimbursements will be based on the new rules starting in 2019.



MACRA signals a major upheaval in Medicare reimbursements and is the next step to drive healthcare providers from a fee-for-service payment system based on volume to a value-based care model where reimbursement is determined by outcomes: quality of care, reduced hospital admissions, lower infections rates, fewer readmissions, better patient outcomes, and improved cost control.

The implications of MACRA for clinicians providing care under Medicare Part B are real and far-reaching. Once MACRA is in place, providers will have to choose to operate under a merit-based incentive program (MIPS) or transition to an Alternative Payment Model (APM). Those who fail to choose one of these two paths will not only be excluded from bonus payments, but will also incur penalties. So although these programs are technically “voluntary,” in reality providers have little choice but to choose one or the other.

The MACRA timeline is aggressive, but unfortunately many organizations have yet to begin even preliminary preparations. Chances are the NPRM won't significantly change between now and the release of the final

regulation in a few months so the change is inevitable. That leaves no time to waste to prepare for the implementation that begins in January.

This paper provides an overview of MACRA and five things you need to be thinking about now as you get ready for full implementation.

## I. Who is affected?

Clinicians billing for professional services under Medicare Part B are subject to the new MACRA requirements. The NPRM also changes the term “eligible providers” to “eligible clinicians” thus expanding the definition to include physicians, dentists, chiropractors, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, physician assistants, physical or speech therapists, and hospital-based eligible providers.

Providers who do not bill for Medicare, Medicaid providers without Medicare patients, or pediatricians are exempt from MACRA’s provisions. Clinicians newly enrolled in the Medicare program, who have \$10,000 or less in Medicare charges, or who have 100 or fewer Medicare patients are also exempt.

Despite these exemptions, there are still more than 100,000 small physician practices that are subject to the law and even CMS says they will be hit the hardest. Estimates in the NPRM show that nearly nine of 10 solo practices will be hit with negative adjustments totaling nearly \$300 million when the reimbursement regulation begins in 2019. Seventy percent of practices with 2-9 eligible clinicians are expected to suffer negative adjustments of \$279 million. That compares to only 18 percent of practices with 100 or more eligible clinicians estimated to suffer negative adjustments of \$57 million.

The financial impact will likely spur the merger or purchase of smaller practices by larger organizations. Some reports suggest increased interest in the merger and acquisition space and activity which is likely to increase as the new regulations take hold. Other alternatives will be practices signing up with ACOs and other provider organizations (safety in numbers).

MACRA doesn’t affect eligible hospitals or critical access hospitals except for mandates in a few areas related to technology:

- Cooperating with the surveillance and oversight of certified EHR technology
- Attesting that the EHR technology being used does not in any way block the bidirectional flow of data

Although MACRA doesn't apply directly to long-term care facilities, it will apply to those institutions that bill Medicare Part B on behalf of the physicians who see their patients.

Although all "eligible clinicians" are subject to MACRA, those who choose the alternate track by significantly participating in a qualifying APM are exempt from the requirements of the MIPS portion of the law. However, the rules can get complicated since clinicians can also be a "hybrid" between MIPS and APM. Being a partial participant in an APM exempts you from certain components of MIPS.

## 2. The Big Decision: MIPS vs. APM

### Merit-Based Incentive Program (MIPS)

According to the NPRM, MIPS is intended to be "a piece of a broader healthcare infrastructure needed to reform the healthcare system and improve healthcare quality, efficiency, and patient safety." MIPS was designed to be "patient-centered, evidence-based, prevention-oriented, outcome-driven, efficient, and equitable."

MIPS is comprised of four components: Quality, Resource Use, Clinical Practice Improvement Activities (CPIA), and Advancing Care Information (ACI). Each receives a weighted score that will be totaled to calculate a composite performance score (CPS). The CPS will then determine provider reimbursement.

**CMS estimates that 90-95 percent of providers will be heading down the MIPS path.**

### Alternative Payment Method (APM)

Although the vast majority of clinicians won't be participating in an APM at the onset of MACRA, CMS expects this track to grow over time as reimbursement models shift from fee-for-service to value-based care.

The stated overall aim of an APM is to increase the quality of care to improve patient outcomes. To further that goal, CMS has developed a portfolio of APMs in which a broad range of physicians and other practitioners can participate. In addition, there are multi-payer options and innovative models in Medicaid and commercial markets that qualify as APMs.

To be considered an Advanced APM, a clinician or organization must meet the following criteria:

- Participant groups must bear more than nominal financial risk (at least 30% of losses in excess of expected expenditures, minimum loss ratio no greater than 4% of expected expenditures, or total potential risk must be at least 4% of expected expenditures)
- Payments must be calculated using evidence-based quality measures that are reliable and valid
- At least 50 percent of participants must use certified electronic health record technology to document and communicate clinical care information in the first performance year (this increases to 75 percent participation in the second performance year)

The key to qualifying as an APM participant comes down to meeting revenue targets. By 2019-20 you must have 25% of your Medicare payments from an advance payment model. That increases to 50% in 2021-2022 and 75% in 2023 and beyond. You can be a partially qualified APM by hitting 20% in 2019-20, 40% in 2021-22, and 50% in 2023 and beyond. Being partially qualified exempts you from some of the MIPS requirements.

### 3. Becoming an APM

It's fairly evident that the APM path is the more difficult of the two choices in MACRA. For those who decide to take that road, however, the American Medical Association has recommended a five-step process to develop an APM.



#### Developing an APM

- Establish a dedicated committee of physicians to begin development of your APM
- Identify specific opportunities to improve patient care that are likely to result in spending reductions
- Identify obstacles in the current payment systems that could prevent implementation and the payment changes needed to overcome these barriers
- Analyze whether the benefits for patients and the saving for payers and patients are sufficient to justify the costs associated with making required payment changes
- Design a payment model that removes barriers and allows physicians to improve patient outcomes while achieving savings for payers

Areas the AMA suggests are potential targets for APM include angina, asthma, cancer, and chronic kidney disease.

### Types of APM structures

MACRA defines any of the following as a qualifying APM:

- An innovative payment model expanded under the Center for Medicare and Medicaid Innovation (CMMI)
- A Medicare Shared Savings Program (MSSP)
- Medicare Health Care Quality Demonstration Program or Medicare Acute Care Episode Demonstration Program
- Accountable Care Organizations (ACOs) (Track 2 and above)
- Patient Centered Medical Homes
- Bundled Payment models

No single APM structure fits the wide range of medical practices. Variations in medical specialties and sub specialties that treat different problems, differences in care delivery systems, and multiple different barriers in current payment systems prevent there being a “one size fits all” APM solution. The AMA has outlined seven types of APMs that address most of the common opportunities and obstacles.

### Payment for high-value service

A practice is paid for delivering one or more desirable services that are not currently billable and physicians take accountability for controlling the use of other, avoidable services for their patients.

### Condition-based payment for physician services

A practice has the flexibility to use the diagnostic or treatment options that address a patient’s condition most efficiently and effectively without concern that using lower cost options would harm the operating margins of the physician’s practice.

### Multi-physician bundled payment

Two or more physician practices that provide complementary diagnostic or treatment services to a patient have the flexibility to redesign those services in ways that would enable high quality care to be delivered as efficiently as possible.

### Physician-facility procedure bundle

A physician who delivers a procedure at a hospital or other facility has the flexibility to choose the most appropriate facility for the treatment and to work with the facility to deliver the procedure in the most efficient and high quality manner.

### **Warranted payment for physician services**

A physician has the flexibility and accountability to deliver care with as few complications as possible.

### **Episode payments for a procedure**

A physician who is delivering a particular procedure works collaboratively with the other providers delivering services related to the procedure (for example, the facility where the procedure is performed, other physicians who are involved in the procedure, physicians and facilities who are involved in the patient's recovery or in treating complications as a result of the procedure) to improve outcomes and control the total spending associated with the procedure.

### **Condition-based payment**

A practice has the flexibility to use the diagnosis or treatment options that address a particular health condition (or combination of conditions) most efficiently and effectively and to work collaboratively with other providers that deliver services for the patient's condition in order to improve outcomes and control the total spending associated with care for the condition.

CMS has also proposed a number of other APM models for consideration by providers including:

### **Next Generation ACO**

An initiative for ACOs that are experienced in coordinating care for populations of patients. It will allow these provider groups to assume higher levels of financial risk and reward than are available under the current Medicare Shared Savings Program (MSSP).

### **Comprehensive ESRD Care Model**

Designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with End Stage Renal Disease (ESRD). CMS will partner with healthcare providers and suppliers to test the effectiveness of a new payment and service delivery model in providing beneficiaries with person-centered, high quality care.

### **Comprehensive Primary Care Plus (CPC+)**

A national advanced primary care medical home model that aims to strengthen primary care through a regionally based, multi-payer payment reform and care delivery transformation. This option will include two primary care practice tracks with incrementally advanced care delivery

requirements and payment options to meet the diverse needs of primary care practices in the U.S.

#### Medicare Shared Savings Program – Tracks 2 and 3

Basically advances the Track 1, one-sided risk model to a two-sided risk model with many of the same program requirements.

#### Oncology Care Model (two-sided risk arrangements)

A new payment and delivery model designed to improve the effectiveness and efficiency of specialty care. Aims to improve higher quality, more highly coordinated oncology care at the same or lower cost to Medicare. Includes physician payment practice financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients.

## 4. Preparing for MIPS

Most providers are initially expected to select the MIPS track beginning in 2017. It is labeled a voluntary program but if you fail to participate and incorporate the requirements into your practice, you will be penalized and will not receive the updated bonus payment. Incentives and adjustments will not be made until January of 2019 but they will be determined by the data you report starting in January of 2017.

The four components of MIPS are Quality, Resource Use, Clinical Practice Improvement Activities (CPIA), and Advancing Care Information (ACI). The AMA has offered these helpful hints on actions you should be taking now to prepare for the implementation of MIPS.



### Quality

This is the performance measure of MIPS and accounts for 50% of the CPS in 2019 decreasing to 45% in 2020 and 30% in 2021 and beyond. This category replaces PQRS and the quality component of the Value Modifier Program.

Reporting will be critical in meeting the requirements of MIPS and this is especially the case in the quality category. Review your current Medicare Physician Quality Reporting System (PQRS) reports to ensure you understand your current metrics reporting requirements and how both PQRS and private payers are scoring you.

Many of the current reporting requirements are the same but there are differences depending on whether you are reporting as an individual or part of a group, your method of data submission, and whether you are patient facing or non-patient facing.

You will need to choose six measures on which to report annually from 200 CMS designated measures, 80% of which are tailored to specialists. You must choose one “cross cutting” measure and one outcome measure. You also need to select two or three population measures. All of the available measures are listed in the appendix of the NPRM and will be updated annually. Access your PQRS feedback reports to help target areas of improvement.

Begin thinking about how you will report your metrics whether through claims, EHR, clinical registry, qualified clinical data registry (QCDR), or group practice reporting option (GPRO) web interface. Be aware that you can receive a bonus point for reporting electronically.



## Resource Use

CMS states that measuring resource use is an integral part of measuring value. The measures for this category are intended to give MIPS eligible clinicians the information they need to provide appropriate care to their patients and enhance health outcomes. This component is aimed at determining what your patients are costing you and what resources they may be using that aren't necessary.

This category accounts for 10% of the CPS and replaces the cost component of the Value Modifier program. CMS will calculate the score for this category based on claims data so no clinician reporting is required. The score is based on 40 measures that vary by specialty and are adjusted for geography and beneficiary risk factors. Take the time to familiarize yourself with the list of episode groups that will be measured.

Use your current Medicare quality and resource use reports (QRURs) to target improvement areas. Identify your most costly patient populations conditions and diagnoses and their related care delivery plans. Review workflows surrounding care delivery plans for improvement opportunities and look for possible partners outside your practice to advance a coordinated care plan.



## Clinical Practice Improvement Activities (CPIA)

CPIA is a completely new category and focuses on the key strategic goals of MIPS: using a patient-centered approach to program development that leads to better, smarter, and healthier care.

This component makes up 15% of the CPS initially and will increase over time. It is based on improvement in selected measures in nine categories: care coordination, beneficiary engagement, patient safety and practice assessment, expanded practice access, population management, achieving health equity, emergency response and preparedness, and integrated behavioral and mental health. Additional areas and activities may be added in future years.

CPIA's are identified as either "high" and awarded 20 points each if they are based on alignment with CMS national programs or require multiple activities. Other activities are weighted as "medium" and given 10 points each. For example, expanding evening and weekend patient visit hours is rated as a "high" activity where timely communication of test results is rated "medium."

You should start by evaluating the list to determine which activities you are already performing and what you need to do to incorporate additional items on the list beginning in 2017. The reporting period for CPIA's is 90 days so you should begin deciding which period in 2017 is best for your organization.

Participants in nationally recognized, accredited, patient-centered medical homes (PCMH), Medicaid medical home models, or organizations recognized by the National Committee for Quality Assurance as a patient-centered specialty model receive full credit in the CPIA category.



## Advancing Care Information (ACI)

In developing the MIPS standards, CMS intended to develop the requirements for the ACI category to continue supporting the foundational objectives of the HITECH Act and Meaningful Use, and to encourage continued progress on key uses such as health information exchange and patient engagement. Their goal is to make this less of a checklist and more of a fundamental shift in the use of healthcare data.

The ACI component incorporates many of the EHR incentive elements and effectively replaces Meaningful Use. It combines a base score and a performance score and accounts for 25% of the CPS.

A key part of the base score is Protecting Patient Health Information. This requires a yes or no response, and if you can't answer "yes," you get ZERO points for the entire ACI component regardless of your other achievements. Plan on conducting a comprehensive security audit of your systems that comply with the HIPAA Security Rule requirements in early 2017. This will enable you to confidently answer "yes" in this category.

ACI mandates the use of certified EHR technology and compels clinicians to report on measures that are specific to its use with an emphasis on interoperability and information exchange. The MACRA categories that replace Meaningful Use are Protecting Patient Health Information, Patient Electronic Access, Coordination of Care Through Patient Engagement, Electronic Prescribing, Health Information Exchange, and Public Health and Clinical Data Registry Reporting.

Compliance in these categories allows you to earn your 50-point base score. You can get "extra credit" and increase your score with performance in the objectives and measures for Patient Electronic Access, Coordination of Care Through Patient Engagement, and Health Information Exchange. These measures have a focus on patient engagement, electronic access, and information exchange that CMS believes promote healthy behavior by patients and advance the goal of interoperability.

You should also make sure you have a 2014 or 2015 Edition certified EHR in place when reporting starts in January 2017. (By 2018, you need to be using a 2015 edition only). By January 1, 2017 you will also need to attest to your support for health information exchange and the prevention of information blocking. You will also have to attest to the Office of the National Coordinator for Health IT (ONC) that you are cooperating with their surveillance and oversight of your EHR.

**Certain clinicians are exempt from the ACI component of MIPS including hospital-based MIPS eligible clinicians, MIPS eligible clinicians with significant hardships, and NPs, PAs, CNSs, and CRNAs.**

You will receive your reimbursement based on your final CPS score. An important note is that reporting data used to calculate these scores is not limited to providers' Medicare beneficiaries.

Since MACRA is a budget neutral law, some clinicians will experience an increase and some will experience a decrease and payments will vary over the years.

## 5. Develop a Plan

The implementation of MACRA will cause massive change for Medicare providers in particular and for the healthcare industry in general. The kickoff is not far away so now is the time to begin preparation. Map out a plan that starts with assessing your current state and create a road map and timeline on how you can ensure compliance with the new requirements.

Consider reading the NPRM. Wading through the 962 pages may be daunting, but you will be better able to decide for yourself what you need to do by gaining first hand knowledge. Take advantage of the avalanche of resource material that is sure to be available as more organizations and industry leaders weigh in on all of the MACRA implications. Read white papers, attend webinars, and take advantage of professional group meetings to get up to speed. Knowledge is power and the more you know, the better prepared you will be.

Educate your staff and encourage them to do additional research. Having everyone in the organization on board will help in the transition. Above all, make sure that throughout the implementation, everyone in your organization maintains a keen focus on patient care.

While there is still time to prepare, January 2017 is not that far away. Now is the time to begin thinking about the impact MACRA will have and what you need to do about it. Putting off the planning process can have severe adverse effects so the sooner you begin the better you will be able to adapt to the changes. Transitioning to MACRA will be a complicated process but with proper preparation, you will be better able to manage the changes to come.

## About Hayes

Hayes Management Consulting is a leading, national healthcare consulting firm and software developer that partners with healthcare organizations to streamline operations, improve revenue and enhance technology to drive success in an evolving healthcare landscape. To learn how Hayes Management Consulting can help support your initiatives, call 617-559-0404 or [requestconsultant@hayesmanagement.com](mailto:requestconsultant@hayesmanagement.com).

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