MINGLE ANALYTICS

Understanding Medicare's New Quality Payment Program

Your introduction to MACRA and getting started with MIPS

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Glossary of Terms

Medicare reporting includes a bundle of terms that many people might be unfamiliar with and that are hard to remember. Here's a quick list of relevant acronyms we'll be referencing throughout this eBook.

ACI / Advancing Care Information

ACR / All-Cause Hospital Readmissions

APMs / Alternative Payment Models

CAHPS / Consumer Assessment of Healthcare Providers and Systems Survey

CMS / Centers for Medicare and Medicaid Services

CPIA / Clinical Practice Improvement Activities

CQMs / Clinical Quality Measures

EC / Eligible Clinician

EHR / Electronic Health Record

GPRO / Group Practice Reporting Option

MACRA / Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act

MIPS / Merit-Based Incentive Payment System

MSPB / Medicare Spending Per Beneficiary

MU / Meaningful Use

PFS / Physician Fee Schedule

PQRS / Physicians Quality Reporting System

PTN / Practice Transformation Network

QP / Qualifying Participants

QPP / Quality Payment Program

QRUR / Quality and Resource Use Reports

SGR / Sustainable Growth Rate

VM / Value Modifier

The Transition Year of MIPS makes it extremely easy for every practice to participate in MIPS and avoid a penalty. Many will be able to earn an incentive.

The final rule makes it easy for practices of every size to succeed under MIPS during the 2017 Transition Year.

When the Centers for Medicare & Medicaid Services (CMS) first rolled out the Quality Payment Program (QPP), there was much concern about the effect on small practices. CMS has addressed that concern, at least for the first year, by making it easy to avoid a penalty.

And any practice that has participated in PQRS (Physicians Quality Reporting System) and Meaningful Use (MU) in the past will find it easy to earn an incentive. Even if you are new to both, success is still within reach.

With this eBook, we'll begin to shed some light on the new rules by:

Breaking down the what and why of MACRA

Explaining each performance path in the Quality Payment Program (QPP)

Detailing how you can succeed in each MIPS category

Helping you prepare for future reporting success

LET'S GET STARTED!

First, we'll cover the basics

What Exactly is MACRA?

The Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act, also known as MACRA, is legislation that brings the Centers for Medicare & Medicaid Services (CMS) one step closer to reimbursing healthcare providers based on quality and cost rather than volume. The program starts in 2017 with the first penalties and incentives being paid in 2019.

But Why the Change?

MACRA, also known as the "doc fix" bill, repealed the flawed Sustainable Growth Rate (SGR) formula which was an attempt to curb Medicare spending. Each year, the cuts that would have been in effect by SGR were postponed and Medicare spending continued to grow.

The Electronic Health Record Incentive Program (Meaningful Use, or MU), Physician Quality Reporting Program (PQRS) and Value Modifier (VM) were other programs in place as an attempt to measure and control the quality and cost of healthcare.

The mix of PQRS, VM and MU created a complicated set of requirements including:

- Confusing time frames
- Overlaps in requirements
- Wasted resources
- Inconsistent measurement and payment adjustments quality and cost of healthcare.

If MACRA was not enacted in 2015, there would have been a 21% cut in Medicare payments under SGR.

With MACRA, providers have more certainty of payments over the next 10 years and the annual fear of payment cuts will be alleviated. This new system aims to combine existing quality reporting programs into one structure to streamline reporting.

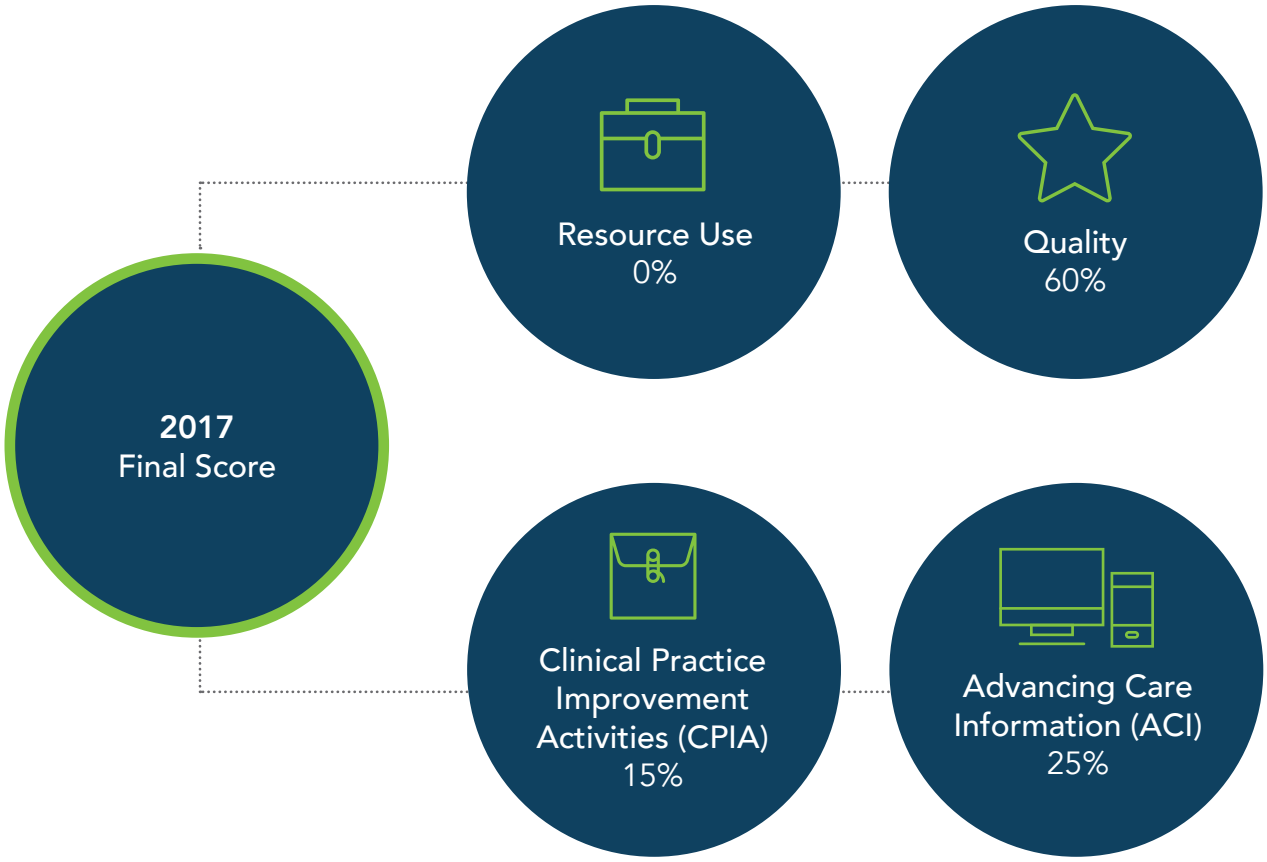
Source: CMANet.com

The New Quality Payment Program (QPP)

MACRA repealed both the SGR and sunset PQRS, VM and MU programs, while instituting a new system: The Quality Payment Program (QPP). The QPP is the latest attempt to control cost and tie payment for services to the quality of care provided. While there are multiple paths through the QPP, CMS expects most physicians will initially participate through the Merit-Based Incentive Payment System or MIPS.

Merit-Based Incentive Payment System (MIPS)

Under MIPS, payments to providers are still based on the Medicare Part B Physician Fee Schedule (PFS) but those payments can be adjusted either up or down depending on their Final Score, which is made up of these four performance categories:



MIPS Performance Categories	Replaces
Quality	PQRS & CMS-calculated measures under VM
Resource Use	CMS-calculated measures under VM
Advancing Care Information (ACI)	EHR Incentive Program (MU) for eligible professionals
Clinical Practice Improvement Activities (CPIA)	New category

We'll dive deeper into each category in the next section.

Based on their Final Score, providers have the potential to have their payments, under the PFS, adjusted by 4%, either positively or negatively. Additionally, positive adjustments can be influenced by two factors:

First, the program is required by legislation to be revenue neutral. CMS will need to distribute the incentives from the money taken in as penalties.

Second, outside of the adjustment schedule and budget neutrality requirements, high performing practices will earn an additional "exceptional performance bonus" in 2019. The rule proposes to increase the base adjustment over time, up to plus or minus 9% by 2022.

Despite the seemingly complex nature of MIPS, CMS has emphasized a desire to simplify and streamline the process for reporting quality data.

New under MIPS, the three categories that require submission of data (Quality, Advancing Care Information and Clinical Practice Improvement Activities) can be submitted through a single vendor.

There is a common submission deadline of March 31. There will no longer be competing and confusing submission deadlines, overlapping vendors or duplication of rules.

Claims reporting for the Quality measures and attestation for Advancing Care Information is still an option. You will choose the reporting mechanism that works for you.

The Qualified Registry submission option has been the most reliable, flexible and cost-effective method for PQRS submission. The proposed changes to the rules promise to make the Qualified Registry method more attractive and effective by allowing the submission of CPIA and ACI as well as Quality.

The Group Practice Reporting Option (GPRO) that worked well for PQRS will also be available through MIPS. If you elect to report as a group in the Quality Performance Category, you will report as a group for the remaining categories.

Alternative Payment Models (APMs)

Under the QPP, providers can participate in an Alternative Payment Model, or APM, which are models that move further from the fee-for-service payment model to models that tie payment to value and focus on better care, smarter spending and healthier people.

Generally, providers band together to operate under an APM—Accountable Care Organizations being an example. CMS' goal is to move providers to at least 50% participation in APMs tied to payment for quality by 2018.

Providers and organizations will receive additional points, within certain MIPS performance categories, for their participation in an APM.

What is an Advanced APM?

Taking new payment models even further, Advanced APMs are payment models in which the organizations share the savings gained by delivering high-quality, low-cost care and assume the down-side risk if the actual cost is higher than it would be under the PFS.

An Advanced APM requires participants to:

- ✔ Use certified EHR technology
- ✔ Base payment on quality measures comparable to those in the MIPS quality performance category
- ✔ Either bear more than nominal financial risk for monetary losses, or act under a Medical Home Model expanded under authority of CMS

For 2017, there are only five Advanced APMs, that have been identified which include:

- Shared Savings Program (tracks 2 and 3)
- Next Generation Accountable Care Organization (ACO) Model
- Comprehensive ESRD Care (CEC) (large dialysis organization arrangement)
- Comprehensive Primary Care Plus (CPC +)
- Oncology Care Model (OCM) (two-sided risk track available in 2018)

CMS has already identified additional APMs that will qualify as Advanced APMs in 2018. The final list for 2018 will be available January 1, 2018.

Are Those Participating in an Advanced APM Exempt from MIPS?

While most providers will be subject to MIPS, those who participate in Advanced APMs and are determined to be Qualifying Participants (QPs) are exempt from MIPS. They receive a 5% incentive and must measure both cost and quality along with other requirements of Advanced APM participation.

Clinicians participating in an Advanced APM are determined to be a QP if they meet the minimum threshold for the percentage of their patients or payments through an Advanced APM. The threshold is scheduled to increase through 2024.

If a provider or practice is not already in one of the five Advanced APMs or don't meet the other requirements by one of the APM snapshot dates, they will file under MIPS. The "snapshot" dates are March 31, June 30 or August 31.

All APMs require an application to CMS for 2017. For some Advanced APMs, the deadline had passed, but CMS extended it to offer the opportunity to increase participation. If someone is not under an Advanced APM contract, they will be subject to MIPS.

Succeeding Through MIPS

Before MACRA, Medicare measured the value and quality of care provided by clinicians through the following programs:

- ✔ Physician Quality Reporting System (PQRS)
- ✔ Value Modifier (VM)
- ✔ Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals

These programs have been modified and incorporated into the new structure of MIPS. If you're already performing well in these categories, you'll likely perform well under MIPS.

More About Your Final Score

What am I Scored on Under MIPS?

The points you receive in the four, weighted performance categories make up your Final Score. Ultimately, how your Final Score compares to the threshold score set by CMS each year will determine whether you receive an incentive or penalty. In the first year of MIPS, each performance category is weighted as follows:

> In 2017, the threshold to avoid the penalty is just 3 points. The threshold for additional points for extraordinary performance is 70 points.

Your Final Score is the aggregate of the weighted score in each category.

Each year, the Final Score threshold will be set prior to the program year and will be based on comparative scores across all MIPS-eligible practices. Providers scoring above the threshold will receive a positive adjustment and those scoring below the threshold will receive a negative adjustment. The adjustments will be "budget neutral" so the dollars produced on the negative side will be distributed among practices on the positive side. There is also an opportunity to earn additional points for extraordinary performance.

Weight of Performance Category Changes by Year

Reporting (Service) Year	2017	2018	2019	2020
MIPS Payment Adjustment	± 4%	± 5%	± 7%	± 9%
Program Year	**2019**	**2020**	**2021**	**2022**
Quality	60%	50%	30%	30%
Resource Use	0%	10%	30%	30%
Advancing Care*	25%	25%	25%	25%
Clinical Quality Improvement Activities	15%	15%	15%	15%
Weighted Final Score	100%	100%	100%	100%

*The weight for ACI could decrease (not below 15 percent) if the Secretary estimates that the proportion of physicians who are meaningful EHR users is 75 percent or greater. The remaining weight would then be reallocated to one or more of the other performance categories.

How to Succeed in Each Category

LET'S GET STARTED!

The score in this category is calculated based on Medicare claims data, meaning there is no data you need to submit.

Even though your Resource Use score will not count in 2017, it will count in future years of MIPS and it's still important to understand how your score is calculated. Resource Use is scheduled to be 30% by 2019.

In this category, CMS examines the claims data to determine the cost of caring for patients attributed to the practice. Patients are attributed to a practice they visit most often for primary care services. Though Resource Use will not factor into the Final Score for 2017, CMS will continue to provide data on Medicare Spending Per Beneficiary (MSPB), total per capita costs for all attributed beneficiaries and costs for ten episode-based measures.

Performance will be influenced not just by charges originating from the group of providers being evaluated, but by other providers who see the same patients.

KEYS TO SUCCEED

To succeed in this performance category, the goal is to keep patients coming back to your practice.

When they look to you for their care, you have better control of who else they see and can make thoughtful choices about referrals to clinical partners who share your approach and are mindful of controlling cost and providing good care.

Adopting the philosophy and practice of a Patient-Centered Medical Home will go a long way to succeed in controlling Resource Use. A Patient-Centered Medical Home keeps patients coming back to you so you provide care when they need it, thereby preventing costly visits to emergency departments. Good tracking and treatment for patients with chronic conditions will also prevent expensive hospitalizations that contribute to the overall cost of care.

Accounting for 60% of your Final Score for 2017, this category aims to prioritize and reward providers for the quality of their patient care based on evidenced-based measures.

The Quality category has two sets of measures:

- ✔ The CMS-calculated measures that are currently determined as part of the Value Modifier (VM)
- ✔ Measures submitted by providers

CMS-Calculated Measures

In 2017, CMS will use just one measure to contribute to your Quality Score: All-cause Hospital Readmissions (ACR). In the future, CMS-calculated measures may include scores for Acute Conditions Composite and Chronic Conditions Composite. The Acute Conditions Composite is made up of scores related to hospital admissions for bacterial pneumonia, urinary tract infections and dehydration. The Chronic Conditions Composite score is made up of diabetes, chronic obstructive pulmonary disease or asthma and heart failure.

Measures Submitted by Providers

The quality measures submitted by providers replace the Physician Quality Reporting System (PQRS), which required clinicians to report on nine measures across three domains. Under MIPS, providers only need to report on six measures, including one outcome measure. If an outcome measure isn't available, selecting another high priority measure is an option.

There will be more than 200 measures to choose from, with 80% being tailored toward specialists who often have a difficult time when it comes to finding suitable measures. CMS has developed a series of specialty measure sets to further help providers select ones that are meaningful and within their scope of practice.

PQRS Measure Groups, with their requirement to report on just 20 patients, is no longer an option.

In 2017, the performance period is just 90 days to earn an incentive. The performance period will increase in future years of MIPS. To prepare for more rigorous reporting requirements, CMS strongly encourages practices to report for a full year, but a full year of data will not increase the incentive.

For Registry reporting in 2017, you must report on patients from all payers that are eligible for the measure, not just patients with Medicare Part B insurance. In future years, the completeness criteria for Registry reporting will increase to a full year of data for 90% of all eligible patients that meet the denominator criteria for the measure for all payers.

The score on the measures will be compared to national benchmarks and each measure will receive 0-10 points within this performance category based on which decile they fall into relative to the benchmark.

> For 2017, every measure reported has a "floor" of 3 points, no matter how far from benchmark.

KEYS TO SUCCEED

For the CMS-calculated measures, similar to the score for Resource Use, focusing on taking good care of patients with chronic conditions and treating acute conditions early to avoid hospitalizations will be your best approach to influencing this score.

For the measures you submit—just as under the Value Modifier (VM)—choosing the right measures to report has become extremely important, because now performance counts.

A HELPFUL TIP

For both the CMS-calculated measures and the submitted measures, take a look at your Quality and Resource Use Reports (QRUR) as far back as you are able. Do you find your scores to be at or below benchmark? While no guarantee, past performance is the best indicator of future performance, unless you radically change how you take care of patients. If your score is below benchmark in any section, look closely at those areas of practice that influence that score.

Providing complete follow ups with your patients post-hospitalization will keep the All-Cause Hospital Readmissions score low— which will be beneficial for this group of measures. Patient-centeredness and hassle-free accessibility remain key elements of success.

Clinical Practice Improvement Activities (CPIA)

In 2017, this performance category accounts for 15% of your Final Score.

Under this new category, MIPS rewards practices that are focused on improvement efforts such as:

- ✓ Care coordination
- ✓ Beneficiary engagement
- ✓ Patient safety

The CPIA category also provides credits for a clinician's participation in APMs and Patient-Centered Medical Homes. There are currently 91 activities proposed which physicians may choose from. The activities are applicable across all specialties and achievable for small practices and those in remote locations.

Some activities carry more points than others and in the Transition Year, you need just 40 points to get "full credit" for this category. If you have Patient-Centered Medical Home recognition or certification, you will receive full credit automatically.

KEYS TO SUCCEED

Review the list of 91 clinical practice improvement activities that you can get points for under this new performance category.

Look for the things you may be doing already that would earn points. You must demonstrate you are doing them for at least 90 days to get credit for the activity. Start planning now to see what you can implement. There are measures that will also earn "bonus" points in ACI.

CPIAs can be anything from a program you already have in place for timely communication of test results, participation in a Practice Transformation Network (PTN) or Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS).

Advancing Care Information

Representing 25% of your Final Score, the Advancing Care Information (ACI) performance category replaces the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals—also known as Meaningful Use (MU).

This performance category eliminates the confusion generated by the overlap in quality reporting for the PQRS and MU program for eligible professionals. The ACI eliminates the MU requirements to report Clinical Quality Measures (CQMs). Instead, under MIPS, all quality measures will be reported through the Quality performance category. **However, MIPS ACI does not remove the Hospital or Medicaid EHR Incentive programs**. Providers who are enrolled in the Medicaid and Hospital MU programs will continue in those programs and in MIPS ACI, if MIPS applies to them.

The Final Rule has decreased the number of required ACI measures from 11 to 5:

- ✓ Security Risk Analysis
- ✓ Electronic Prescribing
- ✓ Provide Patient Access
- ✓ Send a Summary of Care Record
- ✓ Request/Accept a Summary of Care

There are two parts to scoring in this category: a base score and a performance score. For the base scoring on the five measures, you must use the EHR technology for at least one patient for each measure. If you do not meet the five base measures with either a "Yes" or a "1" in the numerator, you will fail in this performance category. A base score on the five measures in this category (along with requirements in other categories) is all that is required to earn an incentive in this first year of MIPS.

If you do meet the base score for the performance score, you will earn points for each measure depending on the number of patients for whom you use the EHR technology.

These categories each contain additional measures that you can use to boost your performance score, including:

- ✓ Patient Electronic Access
- ✓ Patient-Specific Education
- ✓ Secure Messaging
- ✓ Coordination of Care Through Patient Engagement
- ✓ Health Information Exchange
- ✓ Medication Reconciliation

There are also bonus points for reporting to an Immunization Registry, other Public Health and Clinical Data Registries and for improvement activities that use Certified EHR Technology (CEHRT).

Under certain conditions, certain groups of providers do not need to report for this category. The points for this category will be reallocated to other performance categories.

Measure Example: Patent-Generated Health Data

The base score for the Coordination of Care Through Patient Engagement objective for the measure Patient-Generated Health Data requires that you have at least one patient for which you incorporate health data into the EHR.

The performance score for this measure uses the number of unique patients seen by the MIPS-eligible clinician during the performance period as a denominator. The numerator is the number of patients in the denominator for whom data from nonclinical settings—which may include Patient-Generated Health Data—is captured through the certified EHR technology into the patient record during the performance period.

Performance Score Breakdown

KEYS TO SUCCEED

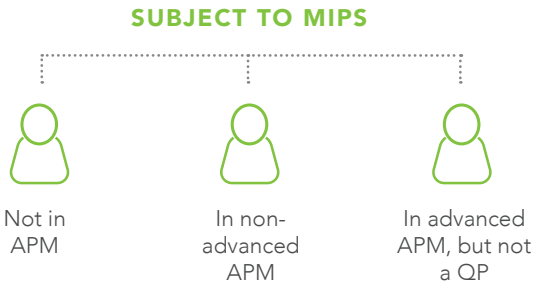
Make sure you are on track to be using EHR technology that is at least the 2014 edition and successfully attest to MU in 2016.

How Do I Know if MIPS Applies to Me?

If you are a physician (MD/DO and DMD/DDS), PA, NP, clinical nurse specialists or a certified registered nurse anesthetist and not participating in an Advanced APM, MIPS **most likely applies to you in the first year.**

NOTE:

Most clinicians will be subject to MIPS



It **does not** apply to you if you meet one of the following criteria:

- ✓ You are a qualifying participant in an advanced APM
- ✓ You are in your first year of participation in the Medicare Part B Physician Fee Schedule (PFS)
- ✓ You treat less than or equal to 100 Medicare beneficiaries or have less than or equal to $30,000 in Medicare Charges
- ✓ You are part of a hospital or facility (ambulatory surgery centers, independent testing labs etc.)

What Can I Do Now to Prepare?

In order to achieve a successful performance score so that your practice gets the highest reimbursement possible, here is what you can do to prepare:

1. Educate your practice on QPP now.

You may want to assign one staff member with the responsibility of tracking and managing the necessary reports and your EHR system.

2. Make sure your EHR is certified by the 2014 edition or later.

Your Advancing Care Information score will be dependent on this and you'll earn additional points in other categories.

3. Select a reporting partner and participate in PQRS in 2016.

Begin building your relationship with a vendor who can report for you in 2016 and on into MIPS for 2017. Learn the measures and choose ones where you can exceed benchmarks. You should look at opportunities to improve starting now.

4. Estimate your MIPS score.

Use your Quality and Resource Use Report (QRUR) and Meaningful Use (MU) reports to see where you fall when comparing cost and quality.

5. Look for opportunities to implement clinical practice improvement activities.

Start planning now to see what you can implement. You must demonstrate you are doing them for at least 90 days to get credit for the activity. You may already be doing things that would earn you points.

6. Identify deadlines and timetables.

Unlike filing your taxes, for MIPS reporting there is no extension. Not reporting will incur an automatic penalty.

7. Stay informed.

Follow our blog for up-to-date information and review our webinars. We hold frequent tutorials and post articles discussing the latest changes and requirements when it comes to Medicare so you're always in the loop.

8. Keep providing high quality care!

MACRA was created to prioritize and reward better patient care, smarter spending and healthier patients, so keep being the best healthcare provider you can be!

Ready for the Quality Payment Program?

We hope this overview of MACRA, MIPS and APMs made the new Medicare reporting process a little easier to understand. It's a complicated system, but using our keys to succeed should help ease the burden and give you a head start for next year!

Mingle Analytics sees the Medicare reporting process from a physician's point of view.

From small practices to large groups, our knowledgeable team is dedicated to helping you find success through expert guidance and unmatched consulting solutions. We also partner with billing companies, EHR vendors and associations to unlock your data and meet your quality reporting needs.

Mingle Analytics evolved from Dr. Dan Mingle's vision for creating a better healthcare system in which care is affordable, practices are profitable, physicians are fulfilled and patients are delighted. A seasoned family physician who is now a nationally recognized authority in healthcare informatics, he and his team are dedicated to helping providers and healthcare systems thrive in the business and practice of medicine.

But Medicare quality reporting is just part of the story. Mingle's expert team is focused on devising data-driven solutions to help clients improve care and lower costs and ultimately transform practice operations to increase the joy and profitability in the practice of medicine.

Let us be your all-in-one reporting solution for success with PQRS and the transition to MIPS under the new Quality Payment Program.

Contact us today for a free consultation with a member of our knowledgeable team.

We will help all practices, small and large, find a quality reporting solution that is right for them.

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