California Medical Association

Navigating MACRA

Scripps Mercy
Physician Partners
May 4, 2017

Elizabeth McNeil
Vice President
Federal Government Relations

CMA
California Medical Association

California Medical Association

No Conflicts of Interest

CMA
California Medical Association

California Medical Association

Goals:

1. Help Physicians Navigate MACRA

2. Help You Prepare Your Practice for Success

CMA
California Medical Association

MACRA

1. Intent of MACRA:
   - Putting It Into Perspective
   - Improvements
2. Overview of MACRA
3. Preparing for MACRA
4. CMA/AMA Advocacy Wins

Putting MACRA Into Perspective

CMA
California Medical Association

Dancing on the Grave of the SGR

Were we premature?

MACRA

MACRA PERSPECTIVE

Private & Public Payers/Patients/Congress

MOVEMENT TO VALUE-BASED PAYMENT

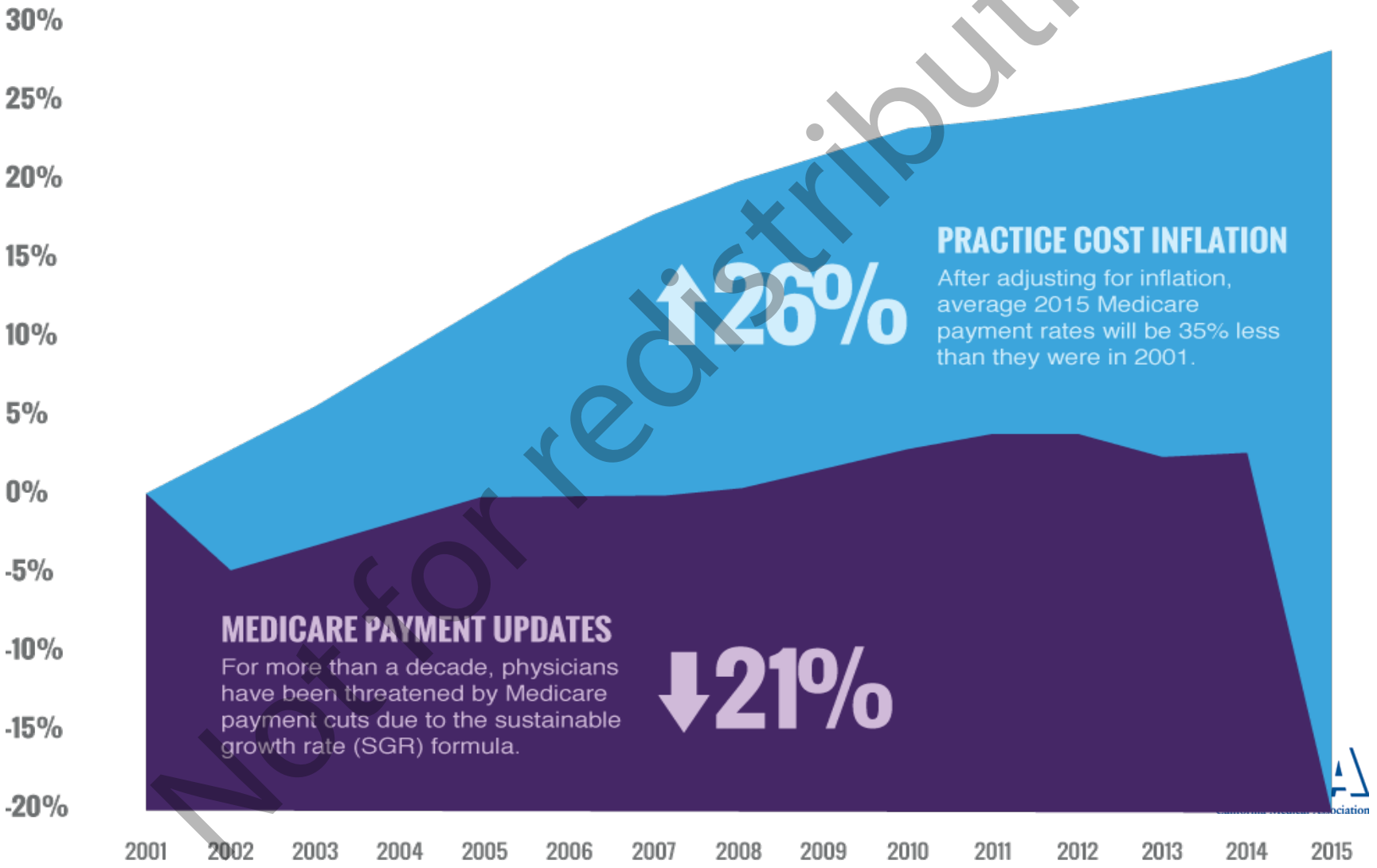
Payment Linked to the Following:

- **Quality**
- **Electronic Health Records and Info Sharing**
- **Efficiency**

CMA PHYSICIAN LEADERS IN DC

Medicare Rates vs. Practice Cost Inflation

Eliminate the SGR



Intent of the MACRA LEGISLATION

1. **Maintain a Fee-for-Service Payment Track**

- **Eliminate the SGR**
- **Provide stable annual updates**
- **REDUCE REPORTING BURDENS**
  PQRS Quality/Meaningful Use/
  Value Modifier Reporting Programs

2. Alternative Payment Model Track

Allow innovative, physician-led alternative delivery and payment models

MACRA LEGISLATION

IMPROVEMENT OVER EXISTING LAW

- Eliminated SGR & provided annual updates
- Simplified burdensome reporting programs
- Reduced penalties in existing law: 11-13%++
  MACRA penalties start at 4%+
- Reinstated substantial BONUS payments
- Physician-led alternative models
- Physicians define quality

MACRA Compared to Current Law: Bonuses, Penalties & Payment Updates

California Medical Association

Year	BONUS (excludes Exceptional Bonus)			PENALTIES			FEE SCHEDULE INCREASES (regardless of performance)		
	Current	MACRA		Current	MACRA		Current	MACRA	
		MIPS[+]	QAPMs		MIPS[+]	QAPMs		MIPS	APMs
2015	0	N/A	N/A	-4.5%	N/A	N/A	-21% under SGR	N/A	N/A
2016	0	N/A	N/A	-6%	N/A	N/A	0%	+0.5%	+0.5%
2017	0	N/A	N/A	-9%	0%	0%	0%	+0.5%	+0.5%
2018	0	N/A	N/A	-10%	0%	0%	0%	+0.5%	+0.5%
2019	0	+4%	+5%	-11% or more	0%*	0%*	0%	+0.5%	+0.5%
2020	0	+5%	+5%	-11% or more	-5%	0%	0%	0%	5%
2021	0	+7%	+5%	-11% or more	-7%	0%	0%	0%	5%
2022	0	+9%	+5%	-11% or more	-9%	0%	0%	0%	5%
2023	0	+9%	+5%	-11% or more	-9%	0%	0%	0%	5%
2024	0	+9%	+5%	-11% or more	-9%	0%	0%	0%	5%
2025	0	+9%	+5%	-11% or more	-9%	0%	0%	0%	5%
2026 +	0	+9%	0%	-11% or more	-9%	0%	0%	+0.25%	+5.75%

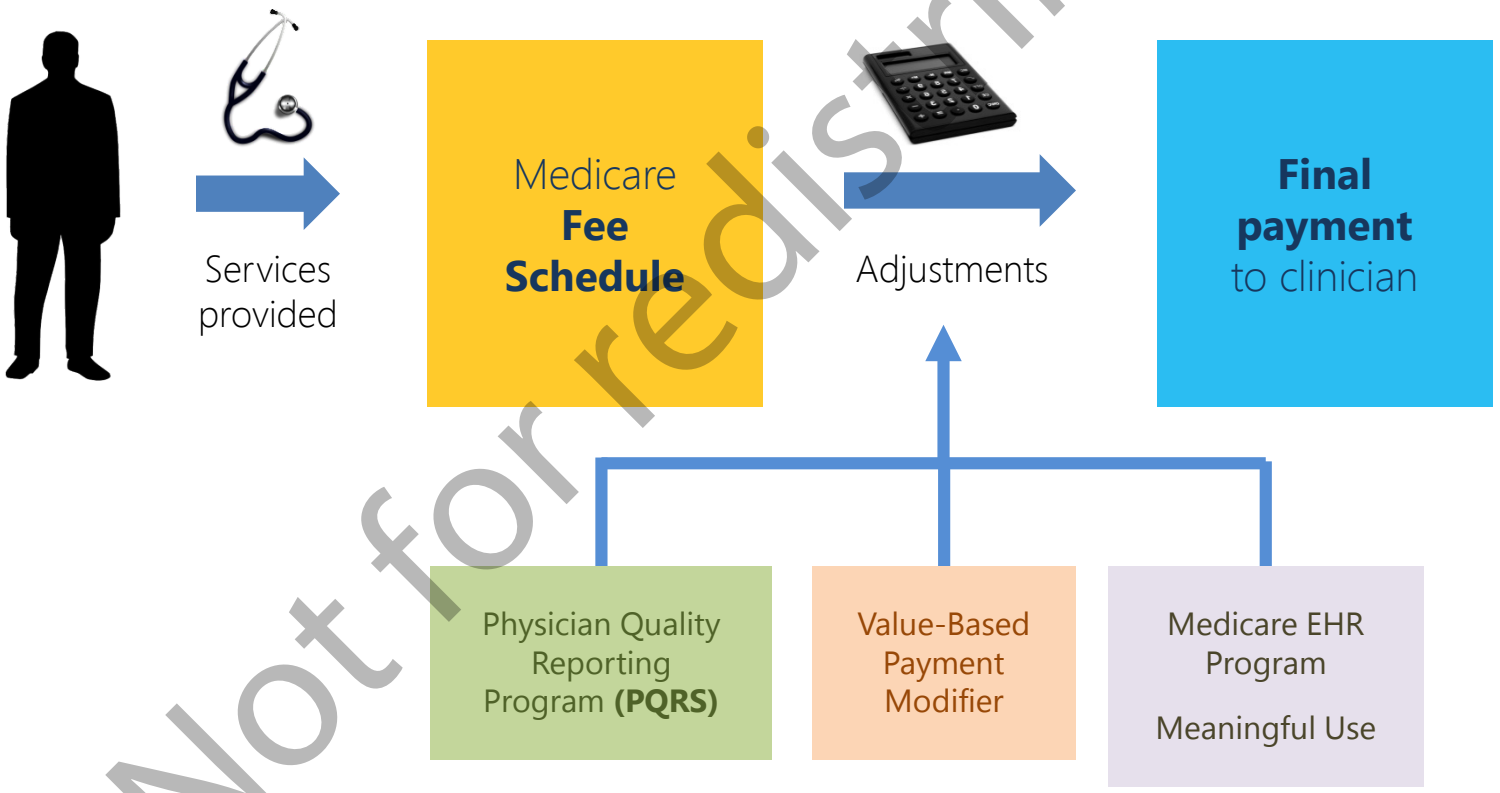
* CMS will not impose penalties for the 2017 performance reporting period for physicians who report for one patient on one quality measure, one improvement activity, or the four required EHR Advancing Care Information measures. However, physicians who choose not to report any performance data will be subject to a 4% penalty.

Putting MACRA Into Perspective

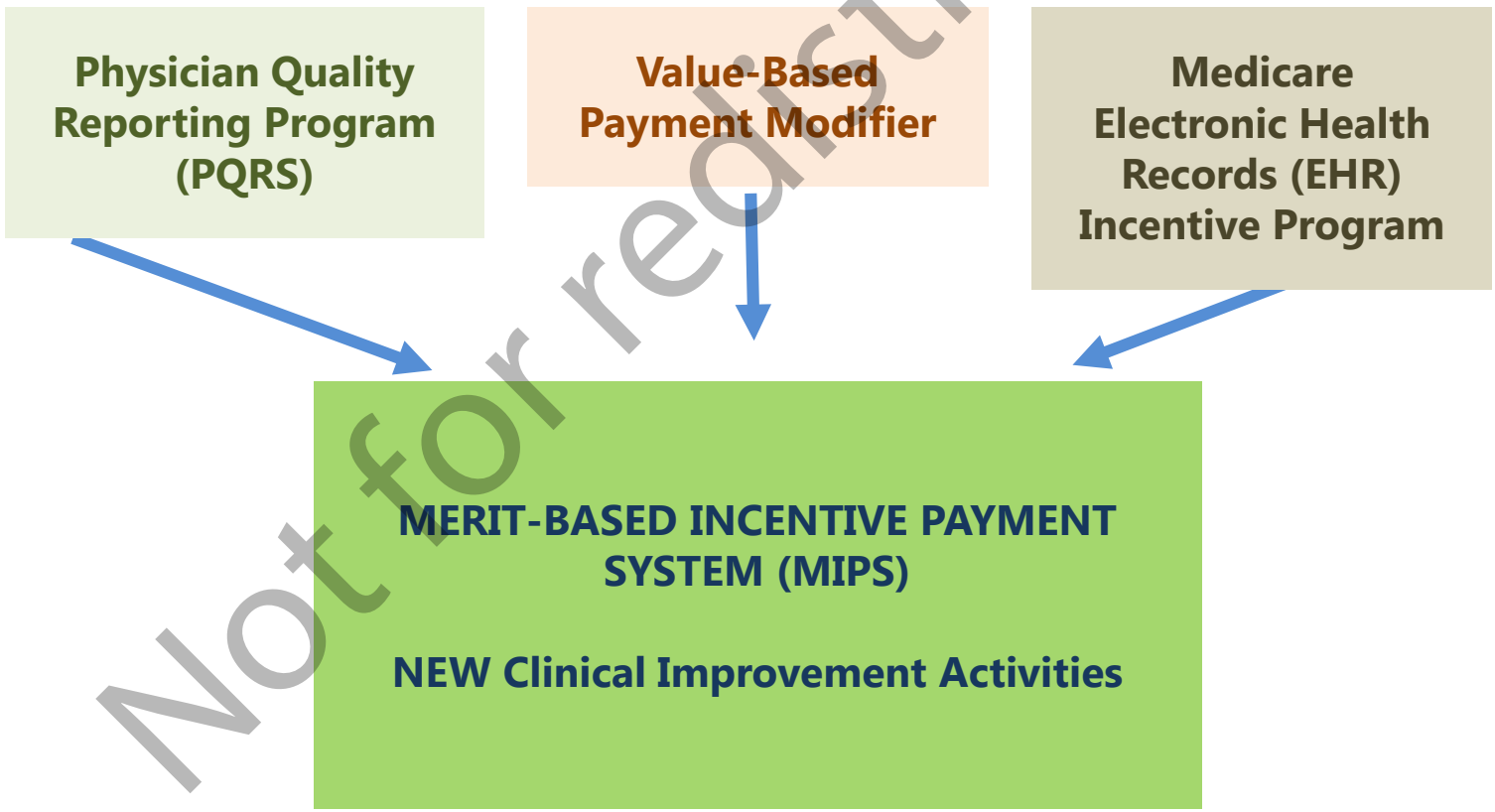
CMA
California Medical Association

Medicare Payments Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on **volume** of services, not **value.**



MACRA LEGISLATION
Revision of Existing Programs



MACRA -MIPS

1. PQRS = Quality
2. MU = Advancing Care Information (ACI)
3. Value Modifier = Cost
4. NEW = Improvement Activities

https://qpp.cms.gov

MACRA FINAL RULE
IMPROVEMENT OVER EXISTING LAW

- **Exempts 30% of Medicare physicians.**
- **Eliminates duplicative quality measures/dbl jeop**
- **Reduces the number of measures by HALF.**
- **Fewer requirements for small/rural practices**
- **Provides a transition path.**
- **Only need to report on 50% of patients.**
- **Eliminates Pass/Fail: Proportional credit given.**
- **More ways to report (claims, EHR, web, QCDR).**
- **Greater selection of applicable specialty measures**
- **Allows Alternative Models**

MACRA FINAL RULE
IMPROVEMENT OVER EXISTING LAW

PROVIDES TRANSITION PATH: PICK YOUR PACE in 2017

1. **TEST YOUR PRACTICE:**
   Eliminates all penalties in first year
   if you submit just one quality measure (see more detail).
2. **PARTIAL YEAR REPORTING**
   Only requires 90 days of reporting (October – December 2017) to avoid penalties and receive a small bonus.
3. **FULL YEAR REPORTING**
   Physicians may report for the entire year; no penalties; modest bonuses.
4. **COST CATEGORY WILL NOT COUNT IN THE FIRST YEAR**

Physicians who do not report anything will receive 4% penalty

CMA
California Medical Association

MACRA

2018 MACRA Rule Released Soon

Expect More Regulatory Relief HHS Secretary Tom Price, MD

CMA
California Medical Association

The Quality Payment Program

The Quality Payment Program has two tracks you can choose from:

Advanced Alternative Payment Models (APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

or

The Merit-based Incentive Payment System (MIPS)

If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

The Merit-based Incentive Payment System (MIPS)

Who will NOT Participate in MIPS?

There are 3 groups of clinicians who will NOT be subject to MIPS:

FIRST year of Medicare Part B participation

Below low patient volume threshold

Certain participants in ADVANCED Alternative Payment Models

Medicare billing charges of $30,000 or less in a given year **OR** see fewer than 100 Medicare Part B patients

Note: MIPS **does not** apply to hospitals or facilities

Take note:

- Changes under MACRA related to the Quality Payment Program do not affect the Medicaid OR Hospital EHR Incentive programs

- For clinicians at FQHCs and RHCs:
  - Services rendered by an eligible clinician, under the RHC or FQHC methodology, will not be subject to the MIPS payments adjustments
  - These clinicians have the option to voluntarily report on applicable measures and activities for MIPS

- To the extent a Tribal/IHS health facility qualifies as either a FQHC or RHC, this same exemption applies.

MACRA -MIPS

Low-Volume Threshold Exemption

- **Physicians with Medicare allowed charges of $30,000 or less**

  OR 100,000 of fewer Medicare patients
- **Eligibility calculated by CMS**

  -Notified in Jan

  -Based on 12-month historical data

  -Includes Part B drug costs but not Part D
- **Exempted physicians receive annual fee schedule updates but not eligible for bonuses or penalties**

When Will Clinicians Learn If They Are Eligible?

December 2016

CMS begins to contact clinicians

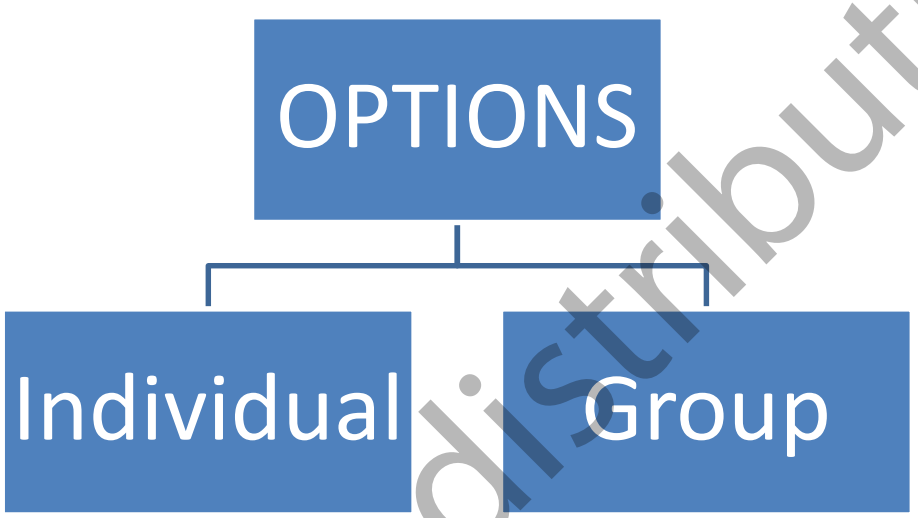
January 2017

NPI Lookup Tool available on Quality Payment Program Online Portal

In the meantime:

- Review your Quality and Resource Use Report (QRUR)
  - https://portal.cms.gov
- Update your Provider Information (NPI, PECOS, etc.)

How Do Clinicians Participate?



1. **Individual:** under an NPI number & TIN where they reassign benefits
2. **As a Group:**
   a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*
   b) As a MIPS APM entity

* If clinicians participate as a group, they are assessed as group across all 4 MIPS categories

MIPS Performance Category: Quality –Reporting

Individual clinicians may report through:

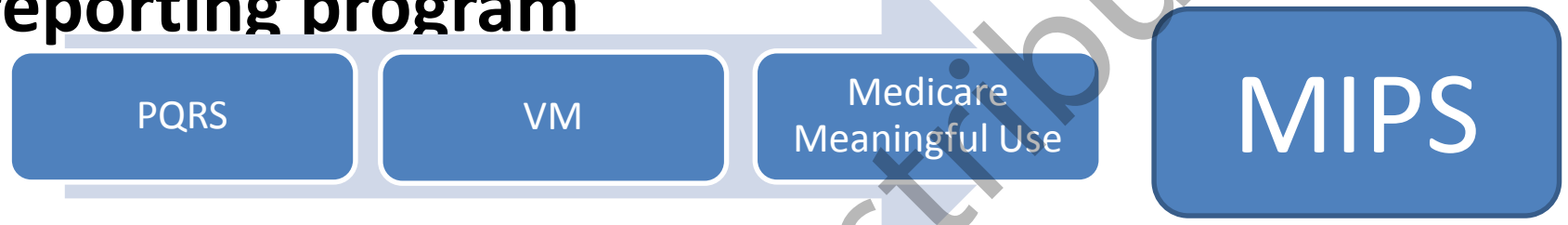
- Qualified Registry
- Electronic Health Record (EHR)
- Qualified Clinical Data Registry (QCDR)
- Claims

Groups may report measures through:

- Qualified Registry
- EHR
- QCDR
- CMS Web Interface (groups of 25 or more)
- CAHPS for MIPS Survey
  - Counts as 1patient experience measure
  - Must submit 5 other measures through a different mechanism above

What Is MIPS?

Combines legacy programs into single, improved reporting program



Legacy Program Phase Out

2016

Last Performance Period under Legacy Programs

2018

End of Payment Adjustments under Legacy Programs

The Timeline for the Quality Payment Program

MIPS PERFORMANCE

Performance Categories:

- Reporting standards align with Alternative Payment Models when possible
- Many measures align with those being used by private insurers

Clinicians will be **reimbursed under Medicare Part B based on this Performance** Score

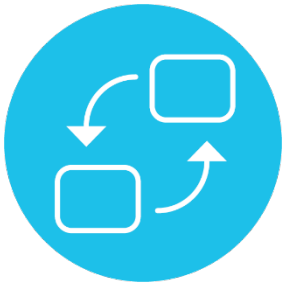
MIPS Performance Categories

Quality

Replaces PQRS

Select 6 measures

1 of 6 must be outcome measure



Improvement Activities

New category 2-4 measure

Shared decision making

Patient Safety

Care Coordination

Access

Advancing Care Information

Replaces Meaningful Use

More flexible Meet 5 measures

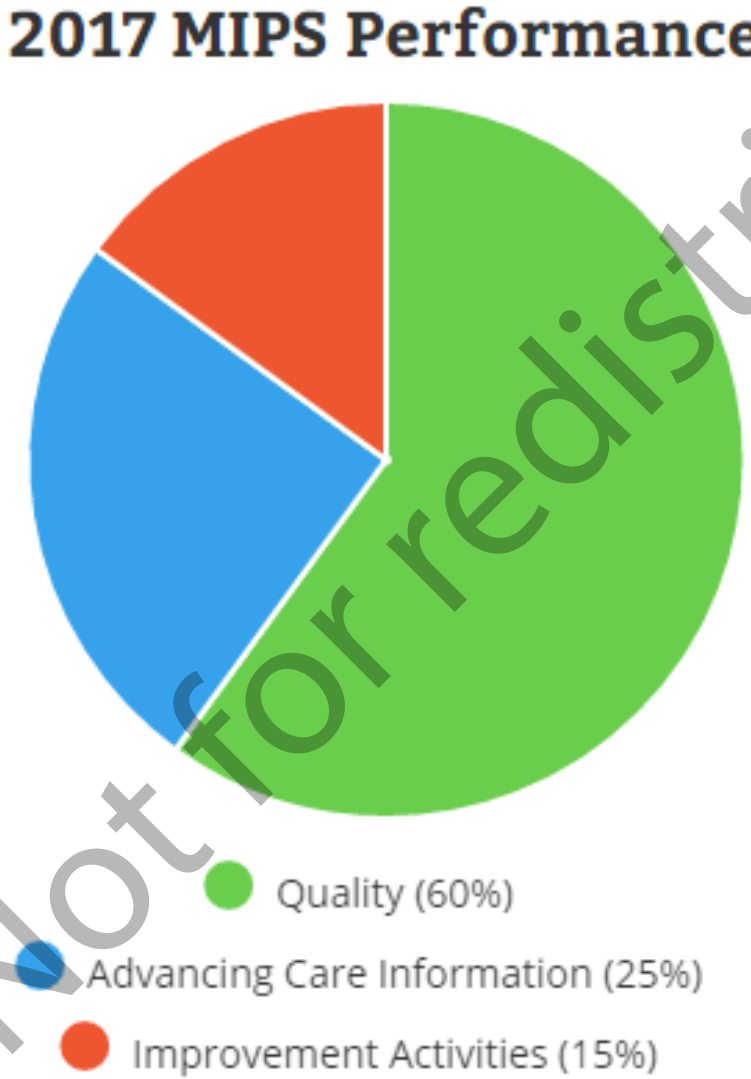
Choose measures that fit your practice and patients

Cost

Uses measures from the Value Modifier Program

No reporting requirement

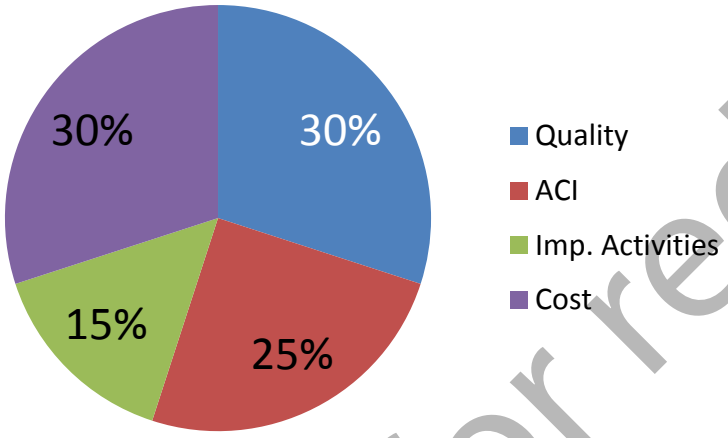
Performance Score Category Weighting



NOTE: These are defaults weights; the weights can adjust in certain circumstances

MIPS component weights (when fully transitioned)

Component Weights



For 2017:
- Quality = 60%
- ACI = 25%
- IA = 15%
- Cost = 0%

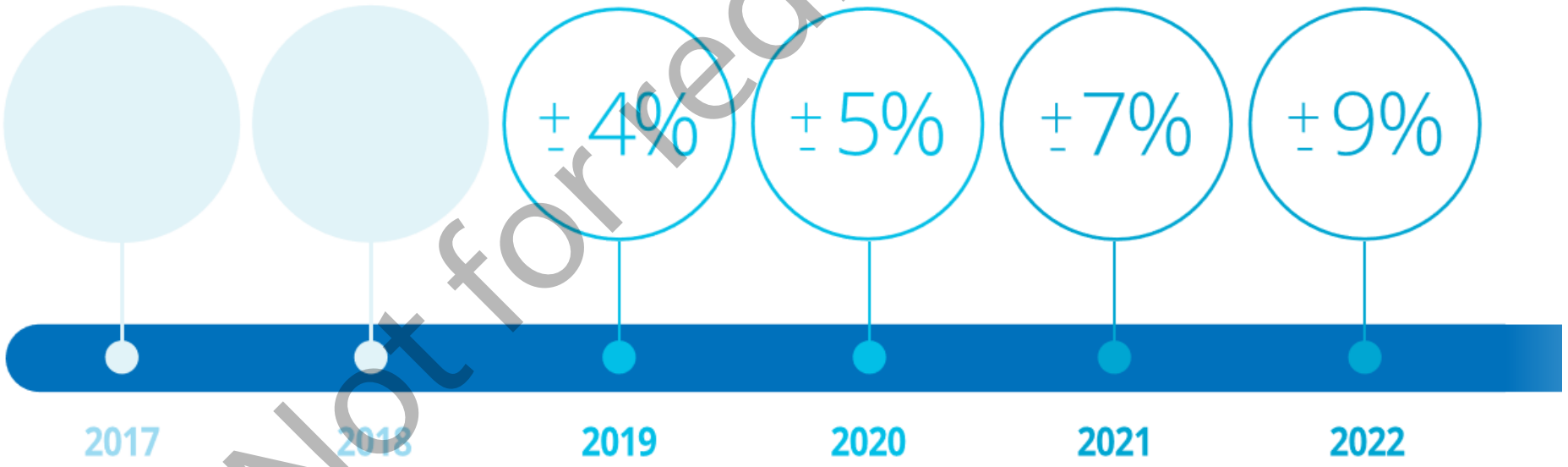
Component Scoring

- **Quality:**
  - 60 points groups ≤15
  - 70 points for larger groups
- **Advancing Care Information:**
  - 50 points base score
  - 90 points performance score
- **Improvement Activities:**
  - 40 points (2-4 activities; 1-2 activities for practices ≤ 15 clinicians, rural practices, and non-patient facing physicians)
- **Cost:**
  - 10 points per measure
  - Score is average of attributable measures

How much can MIPS adjust payments?

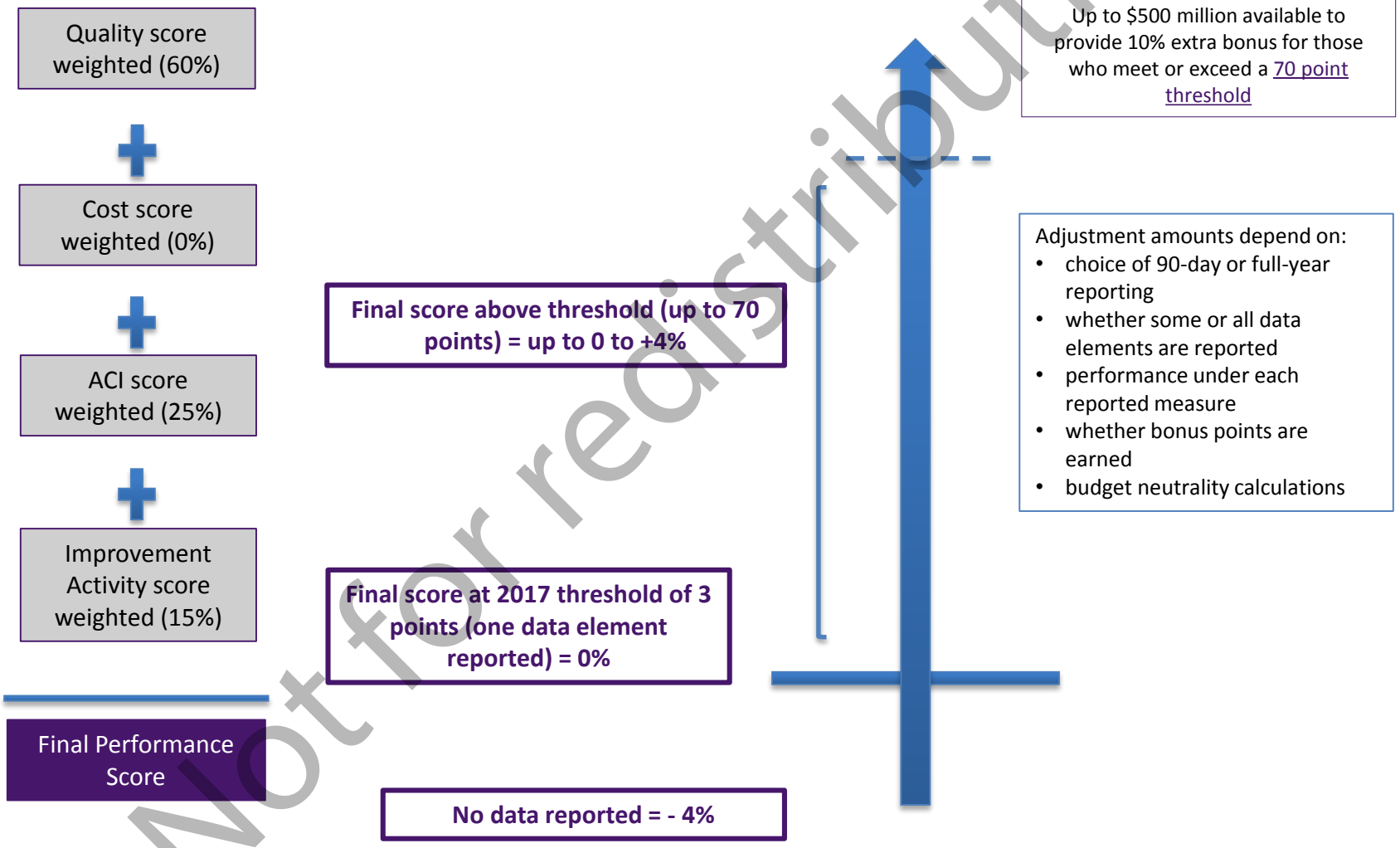
Based on a composite performance score, clinicians will receive **+/- or neutral** adjustments **up to** the percentages below:

MIPS Composite Performance Score → **Adjusted** Medicare Part B **payment** to clinician

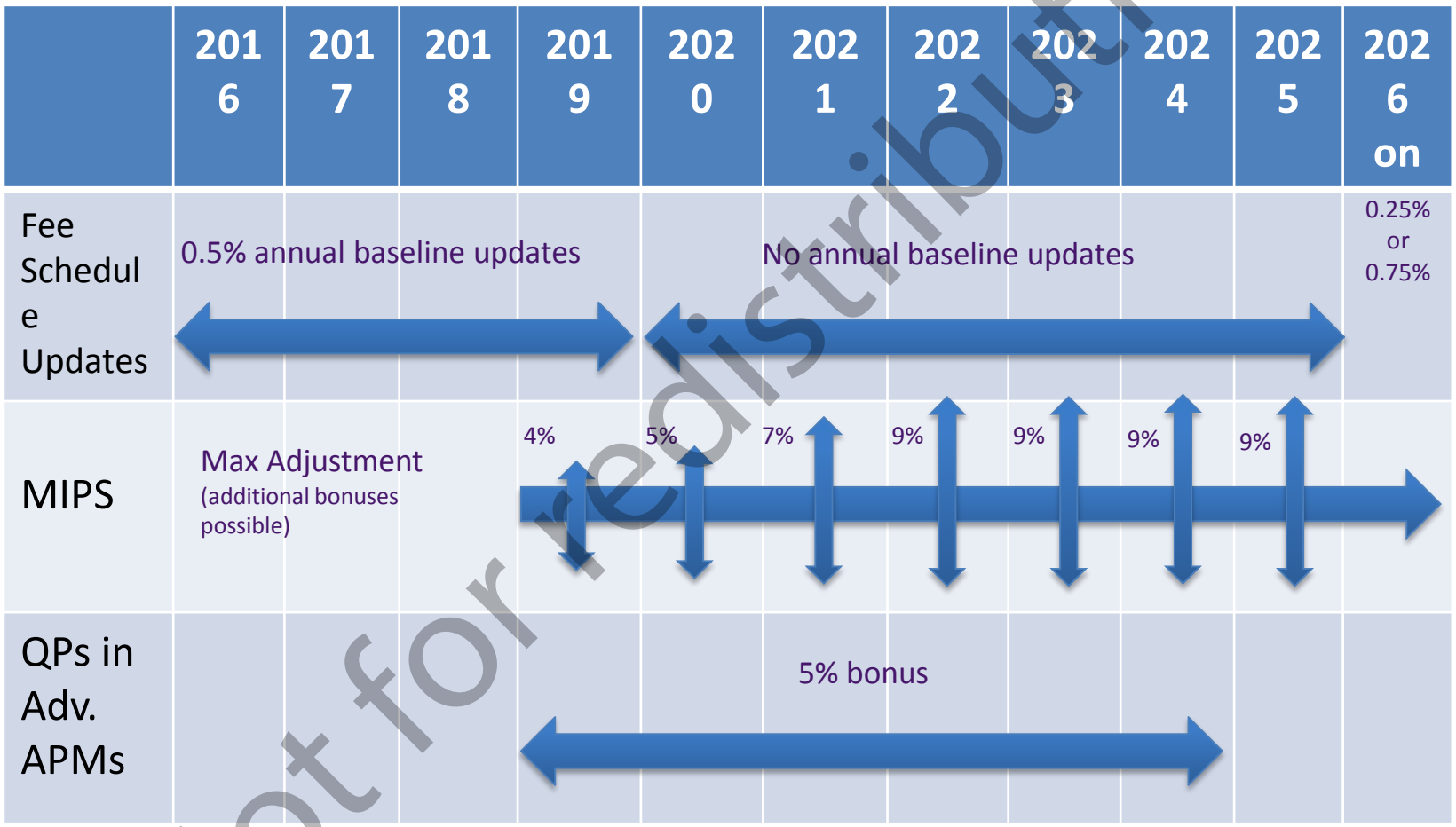


*The potential **maximum** adjustment % will **increase** each year from **2019 to 2022***

2019 Payment Adjustments (Based on 2017 reporting)



Timeline on payment adjustments



The Timeline for the Quality Payment Program

When does the Quality Payment Program start?

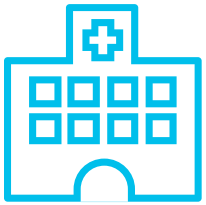
You get to pick your pace for the Quality Payment Program. If you're ready, you can begin January 1, 2017 and start collecting your performance data. If you're not ready on January 1, you can choose to start anytime between January 1 and October 2, 2017. Whenever you choose to start, you'll need to send in your performance data by March 31, 2018.

The first payment adjustments based on performance go into effect on January 1, 2019.

https://qpp.cms.gov

Pick Your Pace during the Transitional Year

Participate in an Advanced Alternative Payment Model



- Some practices may choose to participate in an Advanced Alternative Payment Model in 2017

MIPS

Test Pace

Submit Something

- Submit **some** data after January 1, 2017
- Neutral or small payment adjustment

Partial Year

Submit a Partial Year

- Report for 90-day period after January 1, 2017
- Small positive payment adjustment

Full Year

Submit a Full Year

- Fully participate starting January 1, 2017
- Modest positive payment adjustment

Not participating in the transition year will result in a negative 4% payment adjustment.

Test Participation for 2017

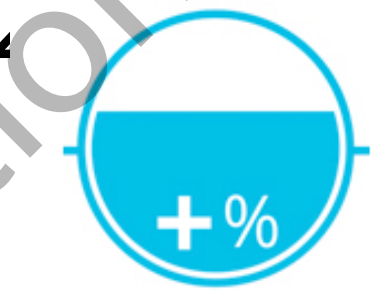
- Submit a minimum amount of 2017 data to Medicare
  - 1 Quality Measure
    (timeframe and amount of data based on measure specifications)

  OR
  - 1 Improvement Activity
    (timeframe and amount of data based on measure specifications)

  OR
  - 4/5 required Advancing Care Information Measures

- Report some data at any point in 2017.
- If you test, you can avoid a reimbursement penalty in 2019

Partial Participation for 2017

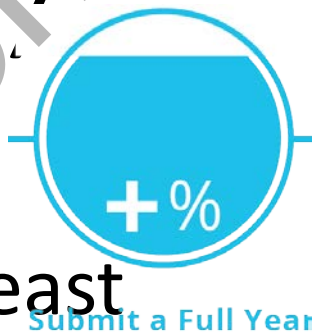


- Submit 90 days of 2017 data to Medicare
  - More than 1 Quality Measure,
  - More than 1 Improvement Activity, or
  - More than the 4/5 required Advancing Care Information measures
- You may earn a neutral or small positive payment adjustment
- (<4%) in 2019

- If you're not ready on January 1, **you can choose to start anytime between January 1 and October 2, 2017**

- **Send in performance data by March 31, 2018**

Full Participation for 2017



- Meet all reporting requirements for at least 90 consecutive days
- You may earn a moderate positive payment adjustment of up to 4%.
- Exceptional performers eligible for additional positive adjustment up to 10%.

MACRA -MIPS
Performance Key Take-Away

Payment adjustments are based on:

- **Choice of 90-day or full year reporting.**
- **Performance data submitted – whether some or all elements reported.**
- **Performance under each reported measure compared to other physicians.**
- **Whether bonus points are earned.**
- **Budget neutrality calculations.**

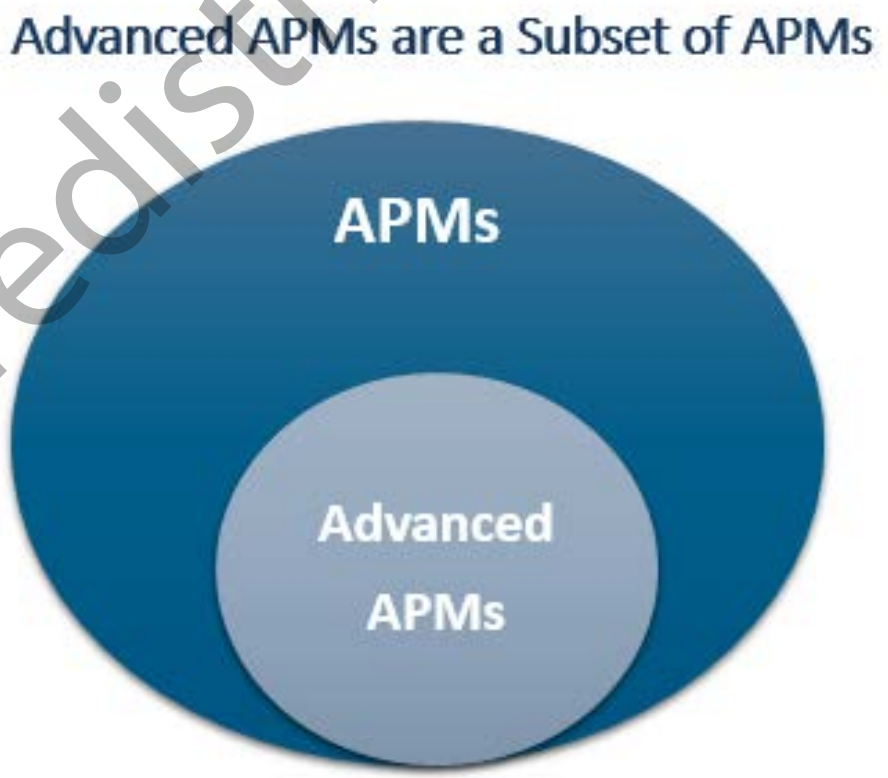
Advanced Alternative Payment Models (APMs)

Advanced Alternative Payment Models

- Advanced Alternative Payment Models (Advanced APMs) enable clinicians and practices to earn greater rewards for taking on some risk related to their patients' outcomes.

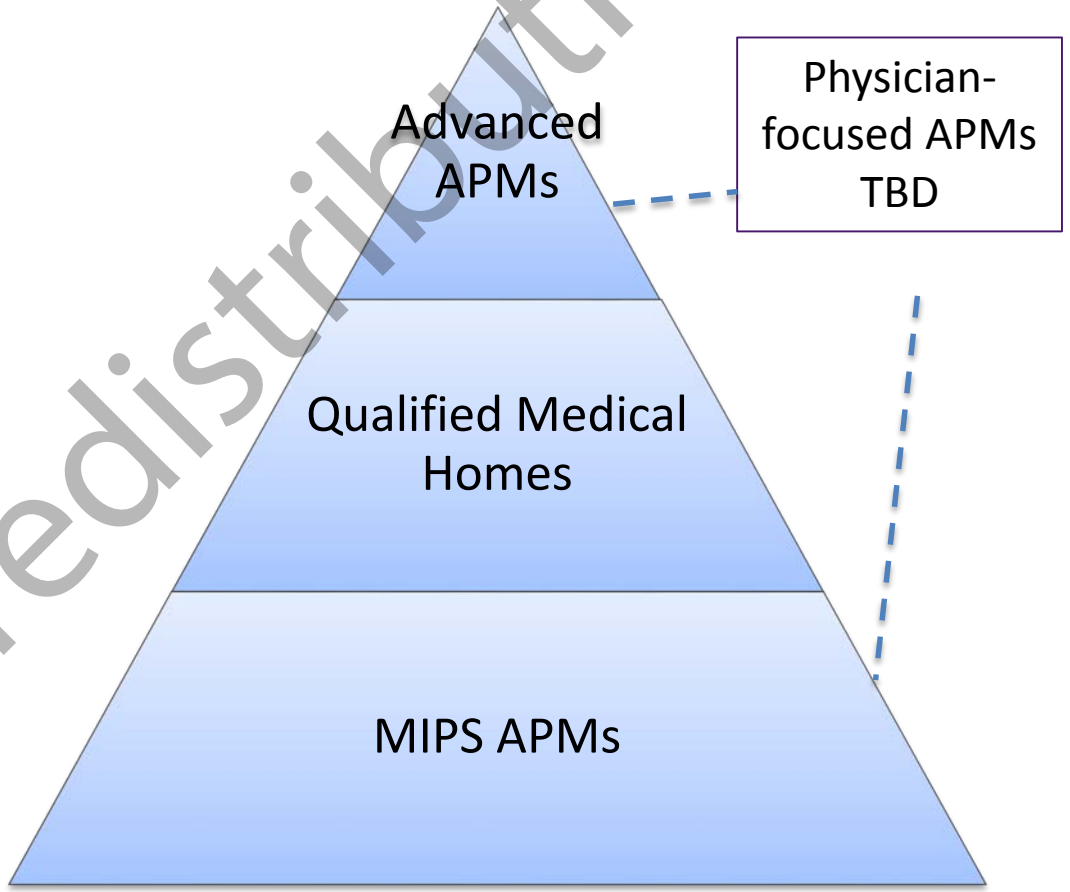
Advanced APMs

Advanced APM-specific rewards
+
5% lump sum incentive
+
More than nominal financial risk



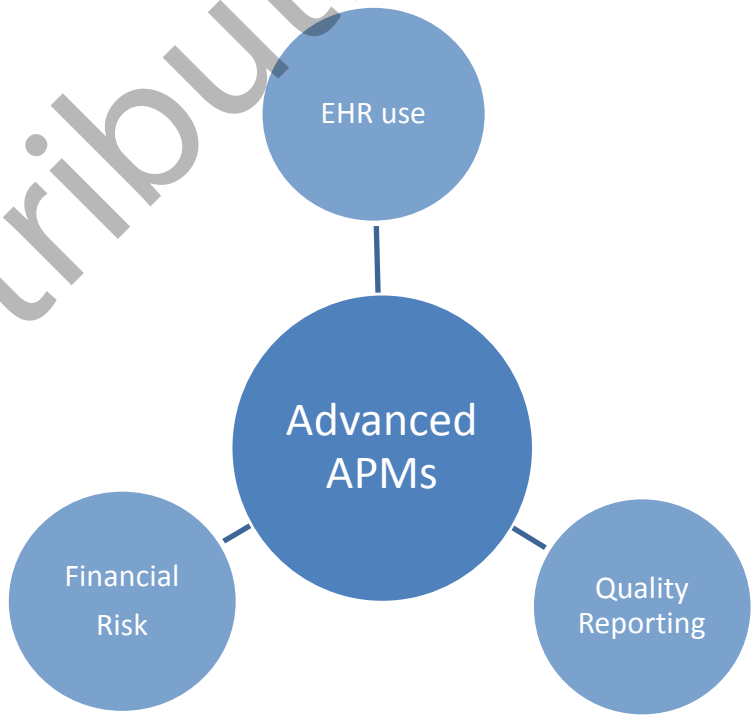
APM participation options

- **"Advanced" APMs**--term established by CMS; these have greatest risks and offer potential for greatest rewards
- **Qualified Medical Homes** have different risk structure but otherwise treated as Advanced APMs
- **MIPS APMs** receive favorable MIPS scoring
- **Physician-focused APMs** are under development



CMS criteria for Advanced APMs

- 50% of participants must use certified EHR technology
- Must report and at least partially base clinician payments on quality measures comparable to MIPS
- Bear "more than nominal risk" for monetary losses
  - Defined as the lesser of 8% of total Medicare revenues or 3% of total Medicare expenditures
  - Primary Care Medical Home models with < 50 clinicians have different standards (2.5%-5% total Medicare revenues)
- Physicians may be Qualified Participants (QPs) or Partially Qualified Participants (PQPs) based on revenue and patient thresholds, with differential rewards



MACRA incentives for Advanced APM participation

Model design

- APMs have shared savings, flexible payment bundles and other desirable features

Bonuses

- In 2019-2024, 5% bonus payments made to physicians participating in Advanced APMs

Higher updates

- Annual baseline payment updates will be higher (0.75%) for Advanced APM participants than for MIPS participants (0.25%) starting 2026

MIPS exemption

- Advanced APM participants do not have to participate in MIPS (models include their own EHR use and quality reporting requirements)

Current Advanced APMs

Comprehensive ESRD Care Model (13 ESCOs)	Comprehensive Primary Care Plus (14 states, practice applications closed 9/15/16)	Medicare Shared Savings Track 2 (6 ACOs, 1% of total)
Medicare Shared Savings Track 3 (16 ACOs, 4% of total)	Next Generation ACO Model (currently 18)	Oncology Care Model Track 2 (A portion of 196 practices will qualify)

New Advanced APMs for 2018 Proposed-only

- ACO Track 1+
- Voluntary bundled payment models
- Comprehensive Care for Joint Replacement Payment Model (CEHRT Track)
- Advancing care coordination through episode payment models Track 1 (CEHRT)
- Vermont Medicare ACO Initiative (all payer ACO model)

MIPS APMs

Criteria

- APM entity participates in a model under an agreement with CMS
- Entity includes at least one MIPS eligible clinician on a participant list
- Payment incentives based on performance on cost and quality measures (either on entity or individual clinician level)

2017 qualified models

- MSSP Track 1 counts

Advanced APM benefits do not apply

- Must participate in MIPS to receive any favorable payment adjustments
- Do not qualify for 5% APM bonus payments 2019-2024
- Not eligible for higher baseline annual updates beginning 2026

Other benefits

- 2017 MIPS APMs receive full Improvement Activities credit
- ACOs: must report quality (50%), IA (20%) and ACI (30%)
- Non-ACO MIPS: quality score reweighted to zero and IA/ ACI reweighted to 25%/ 75%
- APM-specific rewards (e.g., shared savings)
- Eligible for annual MIPS bonuses, which continue indefinitely (vs. 6 years for 5% APM bonuses)

Requirements and payments for APM participants

	Qualified Participant in Advanced APM	Partially Qualified Participant in Advanced APM	MIPS APM participant
Patient and revenue thresholds required	≥25% revenues or ≥20% patients in 2019, rising to 75% or 50%, respectively by 2023	≥20% revenues or ≥10% patients in 2019, rising to 50% and 35%, respectively, by 2023	None
Eligible for APM bonus, higher updates	Yes	No	No
Must participate in MIPS	No	Optional (but no performance adjustments without MIPS)	Yes
MIPS scoring and adjustments	N/A	Favorable weighting and scoring	Favorable weighting and scoring

When Will Clinicians Learn their QP Status for APMs?

- Reaching the Qualifying APM Participant threshold at any one of the three QP determinations will result in QP status for the eligible clinicians in the Advanced APM Entity

- Eligible clinicians will be notified of their QP status after each QP snapshot.

MACRA

PHYSICIAN-FOCUSED PAYMENT MODELS

Submit innovative models to CMS' Physician TAC who makes recommendations to CMS for approval

PREPARING YOUR PRACTICE FOR MACRA:

The Quality Payment Program

CMA
California Medical Association

NEXT STEPS:

BECOME EDUCATED ABOUT MACRA!

CMA MACRA RESOURCE CENTER
www.cmanet.org/MACRA;

- Education Programs and Information
- Links to CMS and AMA Information
- Links to CMS and AMA Navigation Tools
- Specialty Society Clinical Data Registries
- List of Health Information Exchanges

MACRA CHECKLIST

- ✓ Are you exempt from MIPS?
  - ✓ Low volume provider?
  - ✓ Qualified participant in an advanced APM?
- ✓ Do you want to participate as an individual or as a group?
- ✓ Is NPI and PECOS information updated?
- ✓ Do you meet requirements for small, rural, non-patient-facing accommodations?
- ✓ Did you identify measures appropriate for your practice?
- ✓ Do you/ can you participate in a qualified clinical data registry?
- ✓ Can you participate in a Health Information Exchange?
- ✓ Do your PQRS and QRUR reports reveal areas for improvement?
- ✓ Which Improvement Activities are you engaged in now? What are you interested in doing? Did you select 2-4 activities?
- ✓ Is your EHR certified? If so, is it the 2014 or 2015 edition? Does your vendor support Medicare quality reporting?
- ✓ Did you select a reporting Start Date: January 1, 2017 or October 1, 2017

When Will Clinicians Learn If They Are Eligible for MIPS?

December 2016

CMS begins to contact clinicians

January 2017

NPI Lookup Tool available on Quality Payment Program Online Portal

In the meantime:

- Review your Quality and Resource Use Report (QRUR)
  - https://portal.cms.gov
- Update your Provider Information (NPI, PECOS, etc.)

Preparing your practice for MACRA

Getting ready for MIPS.

Should I participate in MIPS as an individual or a group?

Reporting as an individual.

If you send MIPS data in as an individual, your payment adjustment will be based on your performance. An individual is defined as a single National Provider Identifier (NPI) tied to a single Tax Identification Number.

You'll send your individual data for each of the MIPS categories through an electronic health record, registry, or a qualified clinical data registry. You may also send in quality data through your routine Medicare claims process.

Reporting as a group.

If you send your MIPS data with a group, the group will get one payment adjustment based on the group's performance. A group is defined as a set of clinicians (identified by their NPIs) sharing a common Tax Identification Number, no matter the specialty or practice site.

Your group will send in group-level data for each of the MIPS categories through the CMS web interface or an electronic health record, registry, or a qualified clinical data registry. To submit data through our CMS web interface, you must register as a group by June 30, 2017.

www.qpp.cms.gov

MIPS Quality Measures vs. PQRS

MIPS Quality Category-60% of Score

- 1 Administrative Claims Measure

  -All-clause hospital readmission measure for groups of 16 or more (calculated by CMS)
- 6 measures or 1 specialty measure set

  -1 must be an outcome measure

  -If no applicable outcome measure, must report 1 other IA "high priority measure" instead

(i.e., appropriate use, patient safety, patient experience, care coordination)
- To achieve maximum points, measures must be reported on 50% of eligible patients in 2017

Quality Measures by Specialty

- Allergy/Immuno 14
- Anesthesiology 9
- Cardiology 20
- Dermatology 11
- Diagnostic Rad 14
- Emergency Med 15
- Gastroenterology 16
- General Oncology 19
- Gen Practice/Family 55
- General Surgery 14
- Hospitalists 13
- Internal Medicine 37
- Interventional Rad 4
- Mental Health 25
- Neurology 26
- OB/GYN 24
- Ophthalmology 21
- Ortho Surgery 21
- Otolaryngology 18
- Pathology 8
- Pediatrics 18
- Physical Medicine 15
- Plastic Surgery 11
- Preventive Med 17
- Radiation Oncology 4
- Rheumatology 13
- Thoracic Surgery 15
- Urology 12
- Vascular Surgery 15

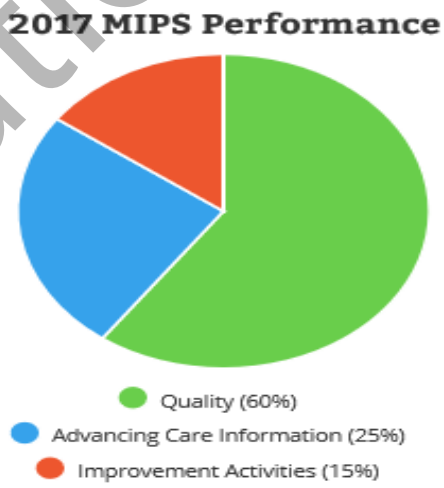
Quality Measures

Instructions

1. Review and select measures that best fit your practice.
2. Add up to six measures from the list below, including one outcome measure. You can use the search and filters to help find the measures that meet your needs or specialty.
3. If an outcome measure is not available that is applicable to your specialty or practice, choose another high priority measure.
4. Download a CSV file of the measures you have selected for your records.

Groups in APMs qualifying for special scoring standards under MIPS, such as Shared Savings Program Track 1 or the Oncology Care Model: Report quality measures through your APM. You do not need to do anything additional for the MIPS quality category.

Note: This tool is only for informational and estimation purposes. You can't use it to submit or attest to measures or activities.



Select Measures

Search All by Keyword: All | Search for... | SEARCH

Filter By: High Priority Measure | Data Submission Method | Specialty Measure Set

Showing **271** Measures

> Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy - Avoidance of Inappropriate Use — ADD

> Acute Otitis Externa (AOE): Topical Therapy — ADD

Selected Measures

0 Measures Added

Once you select measures they will appear here

MIPS Advancing Care Information (ACI) vs. Meaningful Use

MU

- 100% score required on all measures to avoid penalty
- Included redundant measures and problematic CPOE, CDS, and clinical quality measures
- Full-year reporting (although twice reduced in Q4)

MIPS ACI

- Pass-fail program replaced with base and performance scoring
  - 4/ 5 base measures required
  - Partial credit allowed for performance measures
- Fewer measures: CPOE, CDS, and clinical quality measures eliminated
  - Public health registry reporting optional
- Performance score thresholds eliminated
- 90-day reporting periods for 2017 and 2018
- Bonuses available for registry reporting and use of CEHRT in IA

Advancing Care Information

Replaces the Medicare EHR Incentive Program, also known as Meaningful Use.

Fulfill the required measures for a minimum of 90 days:

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Send Summary of Care
- Request/Accept Summary of Care

Choose to submit up to 9 measures for a minimum of 90 days for additional credit.

For bonus credit, you can:

- Report Public Health and Clinical Data Registry Reporting measures
- Use certified EHR technology to complete certain improvement activities in the improvement activities performance category

OR

You may not need to submit advancing care information if these measures do not apply to you.

Cost

Replaces Value-Based Modifier.

No data submission required. Calculated from adjudicated claims.

Next: Explore Quality Measures ›

ACI (EHR) Category-25% of Score

Objective	ACI Measure	Reporting Requirement
Protect patient health information	Security risk analysis	Yes/No statement
Electronic prescribing	E-prescribing	Numerator/ denominator
Patient electronic access	Provide patient access	Numerator/ denominator
Health information exchange	Send summary of care	Numerator/ denominator
Health information exchange (2015 CEHRT only)	Request/ accept summary of care	Numerator/ denominator

2017 ACI (EHR) OPTIONAL Measures

Objective	ACI Measure	Performance score	Reporting requirement
Patient electronic access	Patient-specific education	Up to 10%	Numerator/ denominator
Coordination of care/ patient engagement	View, download or transmit	Up to 10%	Numerator/ denominator
Coordination of care/ patient engagement	Secure messaging	Up to 10%	Numerator/ denominator
Coordination of care/ patient engagement	Patient-generated health data	Up to 10%	Numerator/ denominator
Health information exchange	Clinical information reconciliation	Up to 10%	Numerator/ denominator
Public health/ data registry reporting	Immunization registry reporting	0 or 10%	Numerator/ denominator

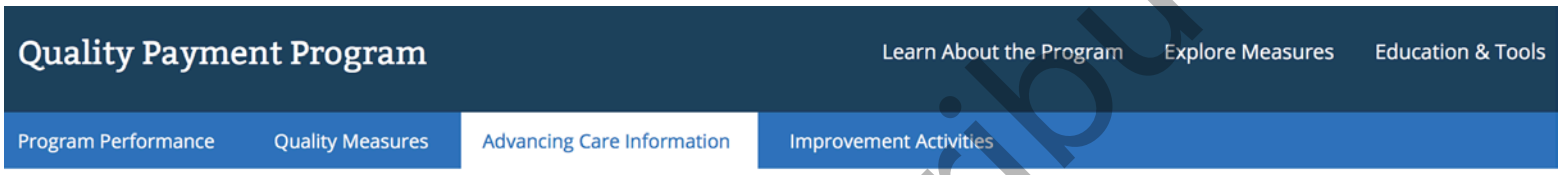
Advancing Care Information (EHR): Bonus Point Scoring

- 5% bonus potential for reporting (via Yes/No statement) to one or more additional public health and clinical data registries:
  - Syndromic surveillance
  - Electronic case (in 2018)
  - Public health registry
  - Clinical data registry
- 10% bonus potential for reporting certain Improvement Activities (IAs) using CEHRT

Advancing Care Information: Next Steps

- **Check that you are using certified EHR technology.**
- **https://qpp.cms.gov/measures/aci;**
- **You will need your EHR brand and version before you go to this link.**
- **Or contact your vendor to confirm CEHRT.**

Advancing Care Information: Next Steps Verifying Certified EHR



Advancing Care Information

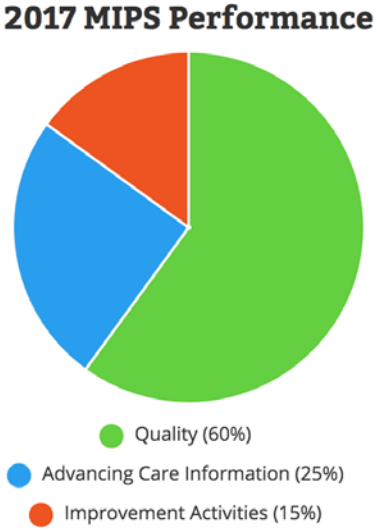
In 2017, there are two measure set options for reporting. The option you use to submit your data is based on your electronic health record edition.

- **Option 1:** Advancing Care Information Objectives and Measures
- **Option 2:** 2017 Advancing Care Information Transition Objectives and Measures

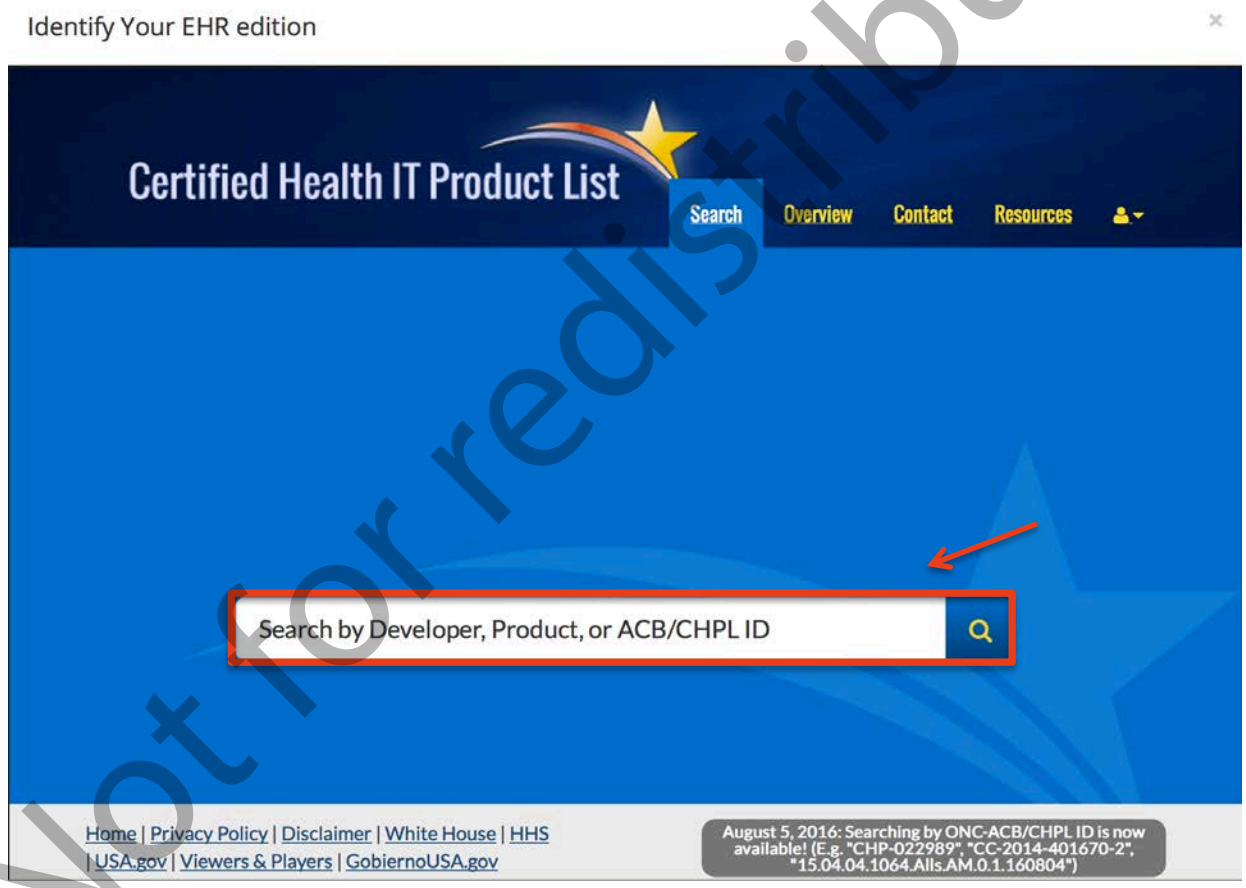
Need help identifying your electronic health record edition?

Instructions

1. Review the advancing care information measures available. Remember, in order to get credit for advancing care information, you must submit information for the required measures.
2. Download a CSV file of the measures for your records.



Advancing Care Information: Next Steps
Verifying Certified EHR



Advancing Care Information: Next Steps

- **Check the Edition of your Certified EHR. Report 4 measures for 2015 edition/5 measures for 2014 edition.**
- **Option 1: Advancing Care Information Objectives and Measures (EHR Technology certified to the 2015 Edition)**
- **Option 2: 2017 Advancing Care Information Transition Objectives and Measures (EHR Technology certified to the 2014 Edition)**

MIPS

Improvement Activities

New category.

Most participants: Attest that you completed up to 4 improvement activities for a minimum of 90 days.

Groups with fewer than 15 participants or if you are in a rural or health professional shortage area: Attest that you completed up to 2 activities for a minimum of 90 days.

Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model: You will automatically earn full credit.

Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Program Track 1 or Oncology Care Model: You will automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.

Participants in any other APM: You will automatically earn half credit and may report additional activities to increase your score.

15%

NEW Improvement Activities Category 15% of Score

- Intended to provide credit for practices improving access and quality – credit for many things you are already doing.
  - Select from over 90 activities in 8 categories
  - No required categories
- Practices larger than 15 physicians report on 2-4 activities (40 points)
- Only 1-2 activities required for groups ≤ 15, rural and HPSA practices, non-patient facing specialists
  - Most physicians fall into this category
- Participation in 2017 MIPS APMs and non-advanced medical homes worth 40 points
  - PCMH definition expanded to include national, regional, state, private payer, and other certifications

Improvement Activities: 90 options in 8 categories

- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary Engagement
- Patient Safety & Practice Assessment
- Achieving Health Equity
- Emergency Response and Preparedness
- Integrated Behavioral & Mental Health

MIPS

Cost

Replaces Value-Based Modifier.

No data submission required. Calculated from adjudicated claims.

Cost Category

0% of Score in 2017

10% of Score in 2018

30% of Score Eventually

Bonuses for physicians spending less than the national average per Medicare patient;

Penalties for physicians spending more than the national average per patient.

Cost in MIPS vs. VBM

VBM

- Included both quality reporting and resource-use measures
- PQRS failure counted twice in penalty calculations
- Poor risk adjustment produced penalties for treating sickest patients
- No statutory limits on penalty risk

MIPS Cost

- Focuses solely on cost; no duplicative quality reporting, no duplicative penalties
- 10 episode groups finalized; others being tested and refined
- Plans to improve attribution methods in 2018 (for 2020 payments)
- Part D drug costs will not be included in calculation
- During 2017 transition, category weight will be zero
  - Reports provided to physicians in transition for review only; will include total costs per capita and Medicare spending per beneficiary

No physician reporting required for this component; calculated by CMS based on claims submitted

CHECKLIST REVIEW

- Make a plan with a timeline.
- Go to https://qpp.cms.gov;

  Review the measures and reporting mechanisms.

  Select 6 quality measures;

  Select 2-4 improvement activity measures;
- Confirm your EHR certification/edition

  https://qpp.cms.gov/aci;
- Contact your vendor for ability to meet the measures and when!

CHECKLIST REVIEW:

- **Check availability of a specialty society qualified clinical data registry to help you report; Links on the CMA & AMA websites.**

  www.cmanet.org/MACRA; AMA links;

- **Check availability of a health information exchange in your area to help with reporting.**

  California E-Health Initiative Website:

  http://caehc.org/hie-in-california-2-2;

Easier Participation for Small and Rural (HPSA) Practices

- **Low Volume rule exempts 30% of physicians.**
- **Provides a 2017 transition path: Pick Your Pace**

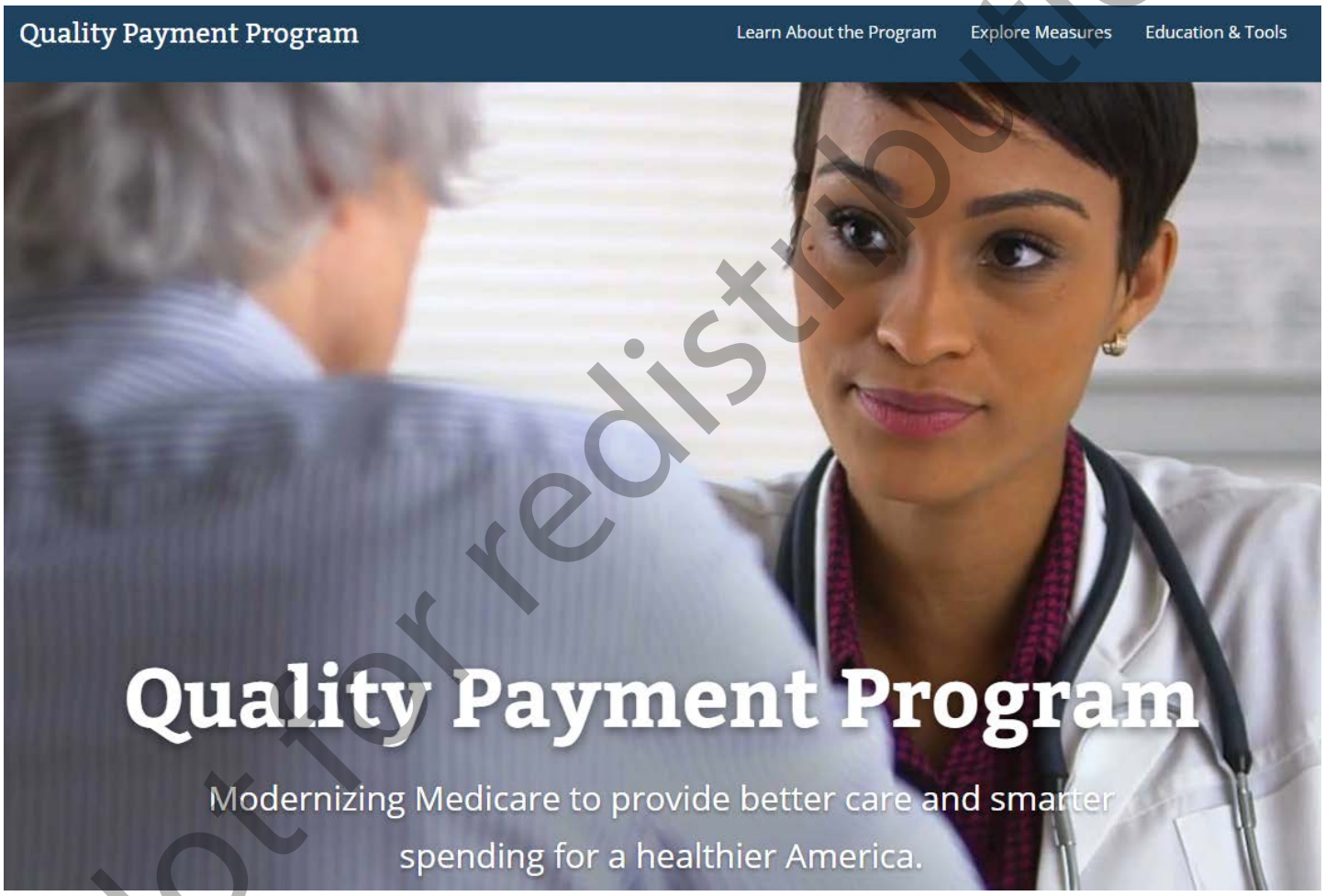
  90% doctors no penalty/some update;

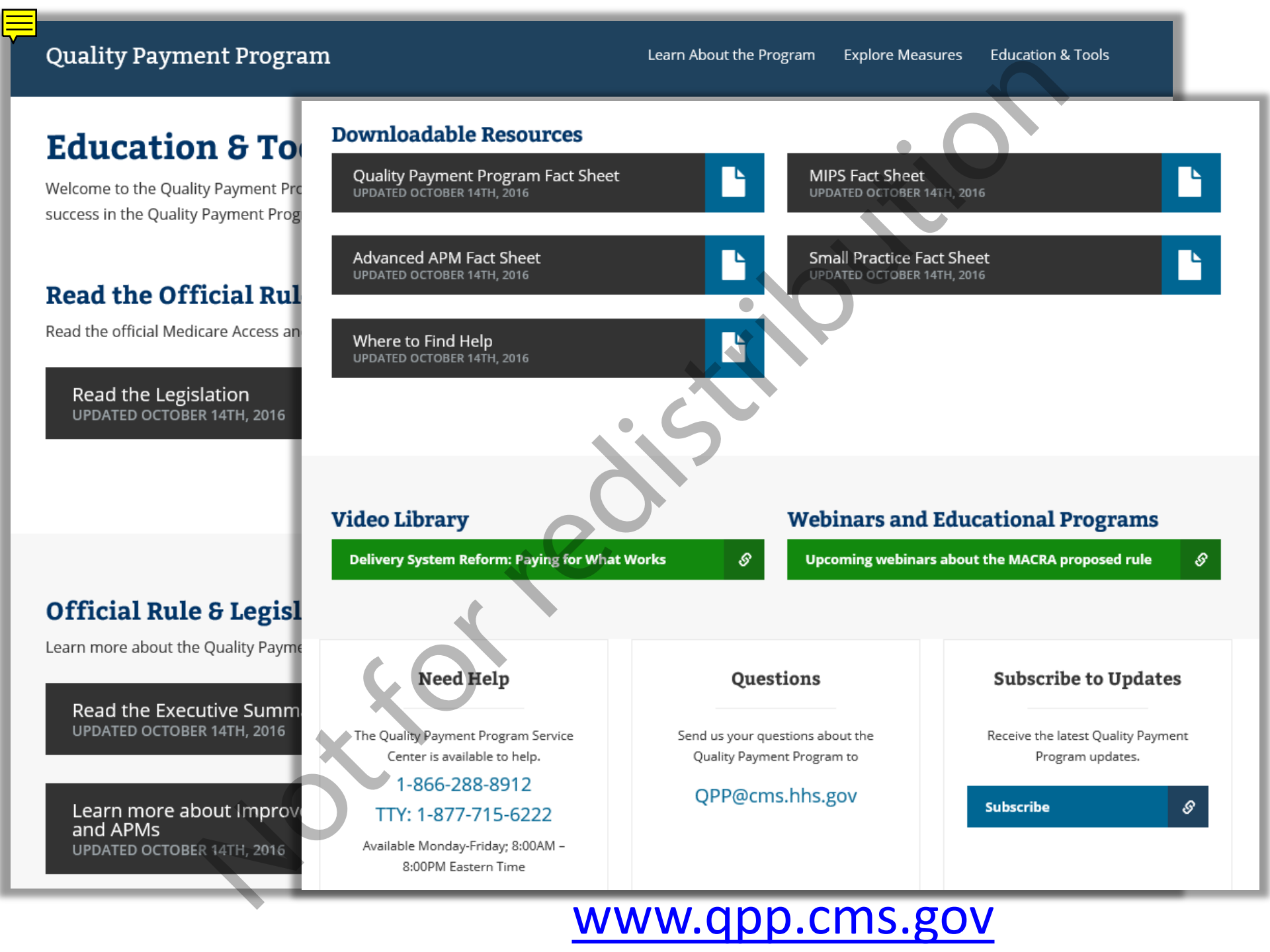
  80% of those are in small practices
- **Reduced number of measures required.**
- **Increasing flexibility for APMS.**
- **Virtual Groups Allowed in 2018.**
- **Technical support forthcoming:**

- $100 million year help small practices

-Transforming Clinical Practice Initiative

Website: https://qpp.cms.gov





www.qpp.cms.gov

What Support Is Available to Physicians from CMS?

Integrated Technical Assistance Program

– **Full-service, expert help**

- Quality Payment Program Service Center
- Quality Innovation Network/Quality Improvement Organizations
- Quality Payment Program — Small, Underserved, and Rural Support
- Transforming Clinical Practice Initiative
- APM Learning Networks

All support is FREE to clinicians

– **Self-service**

- QPP Online Portal

https://qpp.cms.gov/education

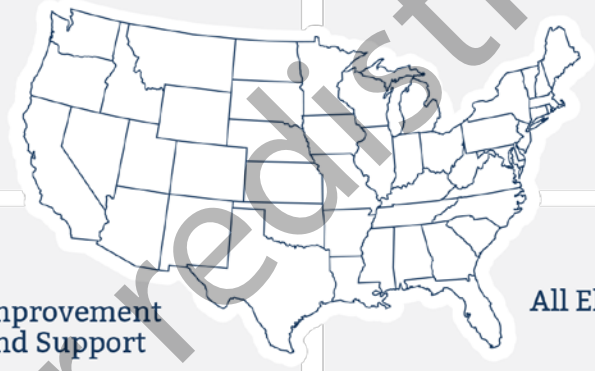
Do you need technical assistance to help you participate in the Quality Payment Program? The Centers for Medicare & Medicaid Services has specialized programs and resources for eligible clinicians across the country.

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.

Locate the PTN(s) and SAN(s) in your state



SMALL & SOLO PRACTICES

Small, Underserved Rural Support Technical Assistance

- Provides outreach, guidance, and direct technical assistance to clinicians in solo or small practices (15 or fewer), particularly those in rural and underserved areas, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - Organizations selected to provide this technical assistance will be available in late 2016.

LARGE PRACTICES

Quality Innovation Network-Quality Improvement Organizations (QIN-QIO) Education and Support

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit- Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Advanced Alternative Payment Model (APM) Learning Networks
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs.

Quality Payment Program: How to get help

Need Help

The Quality Payment Program Service Center is available to help.

1-866-288-8912

TTY: 1-877-715-6222

Available Monday-Friday; 8:00AM – 8:00PM Eastern Time

Questions

Send us your questions about the Quality Payment Program to

QPP@cms.hhs.gov

Ashby Wolfe, MD, MPP, MPH
Chief Medical Officer, Region IX
Centers for Medicare and Medicaid Services
ashby.wolfe1@cms.hhs.gov

California Medical Association

MACRA RESOURCE CENTER

WWW.CMANET.ORG/MACRA

Links to AMA Info/Tools

CMA REIMBURSEMENT HOTLINE

888-401-5911

(For CMA members only)

MACRA

CMA/AMA's Advocacy To Improve the Final Rule

CMA
California Medical Association

MACRA PROPOSED RULE
CMA General Recommendations

1. **Delay the performance reporting from Jan 1, 2017 to Jan 1, 2018**

   October 1, 2017

2. **Reduce the Scoring Complexity**

   TBD

CMA
California Medical Association

MACRA PROPOSED RULE
CMA Advocacy

1-Accommodations for Small/Rural are Inadequate

Help Small & Rural Practices (Penalties)

- ✓ **Expand the exemptions**
- ✓ **Allow penalty exemptions during a phase-in transition period**
- ✓ **Provide safe harbors from penalties until Virtual group reporting is established.**
- ✓ **Exempt Medicare-Medicaid Dual Eligible Patients so Physicians not penalized**

MACRA PROPOSED RULE
CMA Advocacy

2-Reporting Programs Still Too Burdensome

Further Reduce Reporting Program Burdens

- ✓ **Further Reduce # of measures**
- ✓ **Reform EHR Category**
- ✓ **Provide Partial Credit for all categories**
- **Uniform among all payers**

CMA
California Medical Association

MACRA PROPOSED RULE
CMA Advocacy

3-No Accountability On EHR Vendors

More Accountability & Enforcement on Vendors

- **Penalties for non-compliance and data blocking**
- ✓ **Vendor certification revoked for data blocking.**
- ✓ **Hardship exemptions.**
- **Physicians made whole by vendors that lose certification and physicians granted hardship exemption.**

MACRA PROPOSED RULE
CMA Advocacy

4-Resource Use program discourages physicians from treating vulnerable patients – Needs Improvement

- ✓ **Resource Use Category – Doesn't Count in 2017**
- **Exemption or bonus points for physicians treating Medicare-Medicaid Dual Eligible Patients.**
- **Methodology improvements for subspecialty comparisons; socioeconomic status of patients.**
- **Physicians within 1-2 standard deviations of natl average should be rewarded.**

MACRA PROPOSED RULE

5-The APMs are too limited and financial risk requirements too high

Alternative Payment Models (APMs)

- ✓ **More opportunities for Physician-led models**
- ✓ **Allow Track 1 ACOs**
- ✓ **Reduce financial risk; exempt start-up costs**
- ✓ **Spending benchmarks set at the natl ave**
- ✓ **Promote medical homes (primary & specialty)**

California Medical Association

CMA Will Stand By You To Continue to Reduce Medicare Reporting Burdens

CMA
California Medical Association