A Brief Introduction to MACRA, the Medicare Quality Payment Program and MIPS

This document presents an overview of a new Quality Payment Program that affects Medicare Part B payments to clinicians. The program is part of MACRA (Medicare Access and CHIP Reauthorization Act of 2015) and provides financial incentives to clinicians for delivering high-value care.

The content of the document is based on published materials from the federal Centers for Medicare & Medicaid Services; graphs and figures were extracted directly from these materials.

Executive Summary

- The MACRA Quality Payment Program changes the way Medicare pays clinicians and offers financial incentives for providing high-value, patient-centered care.
- Your performance under the Quality Payment Program will determine whether your Medicare Part B payments will be adjusted up, down or not at all.
- You can participate in this program in one of two ways: by either taking part in an Advanced Alternative Payment Model (APM) or by participating in the Merit-Based Incentive Payment System (MIPS). If you do not participate in an advanced APM, then you must participate in MIPS.
- In MIPS, payment adjustments are based on your performance on evidence-based and practice-specific performance measures. MIPS consists of four performance categories; each has its own measures and reporting requirements and each has a separate weight in the calculation of a MIPS composite performance score. The categories and weights for 2017 are: Quality (60%), Improvement Activities (15%), Advancing Care Information (25%) and Cost (0%). *(Note: Participation in the Michigan Surgical Quality Collaborative can help you satisfy the requirements of the Improvement Activity category)*
- You can participate in MIPS as an individual or as part of a group. If you participate as a member of a group, your payment adjustment will be based on the performance of the group as a whole.
- A single MIPS composite score will be calculated as the sum of the weighted performance in the four performance categories. The composite score will be compared to MIPS performance thresholds to determine the payment adjustment percentage for the individual clinician or group of clinicians.
- Payment adjustments based on performance in 2017 will be between -4% and +4% and will be applied to payments for services in 2019; payment adjustment percentages will grow in subsequent years.
- Clinicians must collect data starting anytime between January 1 and October 2, 2017. You must submit the data by March 31, 2018 to avoid a payment penalty in 2019.
- Your Medicare payments will be adjusted up, down or not at all, depending on the amount of data you submit for 2017 and your performance results. If you do not submit any data, your payment will be adjusted down by 4%.

Prepared for MSQC by Vinita Bahl, D.M.D., M.P.P., February 2017

What are MACRA and the Quality Payment Program?

MACRA (Medicare Access and CHIP Reauthorization Act of 2015) was instituted to end the Sustainable Growth Rate Formula, which threatened clinicians with Medicare payment reductions during the past 13 years.

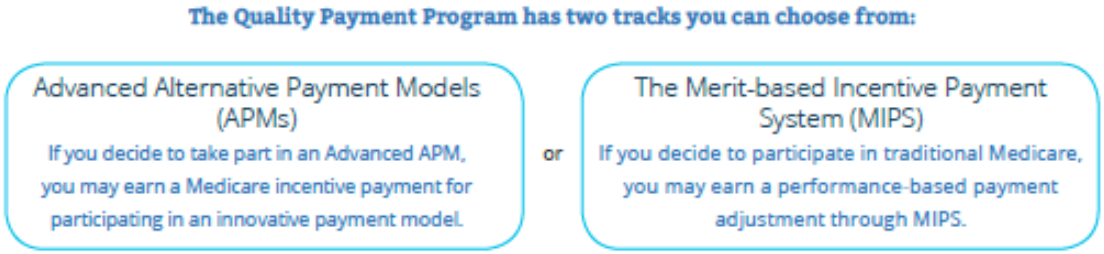
MACRA is the term often used to describe one of its key provisions - the Quality Payment Program. This program changes the way Medicare pays clinicians and offers financial incentives for providing high-value, patient-centered care.

Here are a couple of key points about the Quality Payment Program:

- Your performance under the program determines whether your Medicare Part B payments will be adjusted up, down or not at all.
- The Quality Payment Program replaces the current Physician Quality Reporting System (PQRS), Meaningful Use and Value-Based Payment Modifier (VM) programs.

How Will Physicians Participate in the Quality Payment Program?

You can participate in this program in one of two ways: by either taking part in an Advanced Alternative Payment Model (APM) or by participating in the Merit-Based Incentive Payment System (MIPS)



APMs give incentive payments for high-quality, cost-efficient care and can apply to a specify clinical condition, care episode or population. Advanced APMs are a subset of APMs and give providers an opportunity to earn more for taking on some risk related to their patient's outcomes.

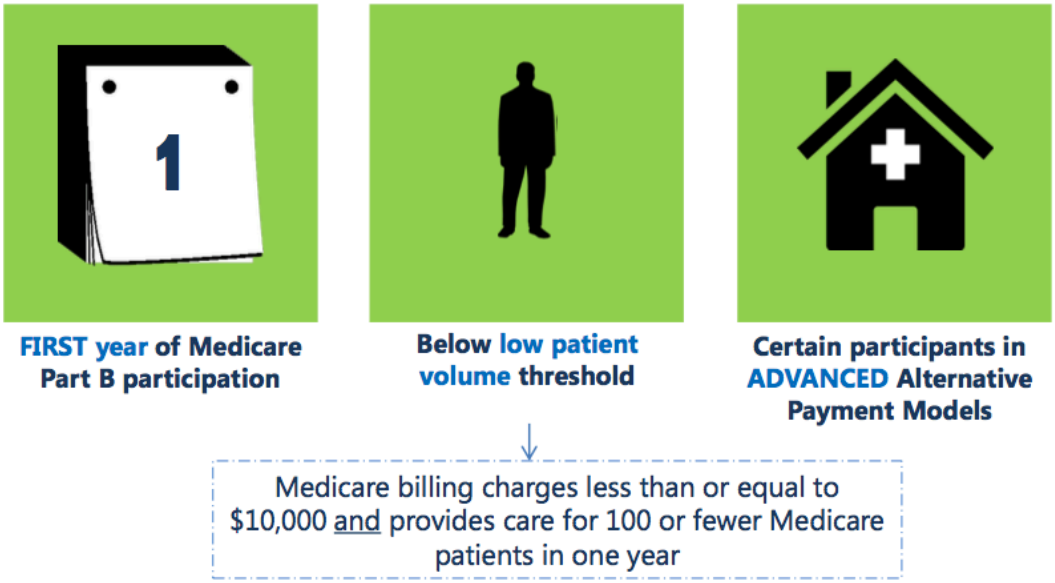
Here are the Advanced APMs recognized by the Quality Payment Program. (Click on a link for any of these Advanced APMs to access their website and learn more)

Comprehensive ESRD Care (CEC) - Two-Sided Risk, Comprehensive Primary Care Plus (CPC+), Next Generation ACO Model, Shared Savings Program - Track 2, Shared Savings Program - Track 3, Oncology Care Model (OCM) - Two-Sided Risk, Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT), Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

If you do not participate in an advanced APM, then you must participate in MIPS. Most practitioners will be subject to MIPS.

Which Clinicians Are Excluded from MIPS?

Clinicians (Physicians, PAs, NPs, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists) that meet any of the following specific criteria are not required to participate in MIPS.



How Will Clinicians Satisfy MIPS Requirements?

In MIPS, payment adjustments are based on your performance on evidence-based and practice-specific performance measures. There are four performance categories for MIPS and each has its own measures and reporting requirements:

Performance Category and 2017 Category Weight	What Do I Need to Know? What are the Requirements?
 	• Replaces PQRS • Report up to 6 of about 300 quality measures (minimum of 90 days to be eligible for maximum payment adjustment); 1 must be an outcome measure OR a high-priority measure, defined as an outcome measure, appropriate use measure, patient experience, patient safety, efficiency measures or care coordination. • May select specialty-specific set of measures • Different requirements apply for groups reporting via CMS Web Interface or those in MIPS-qualifying APMs (i.e., selected APMs that are not included in the subset of advanced APMs, like Medicare Shared Savings Track 1).
  * Improvement Activities is a new performance category; it does not replace any previous value-based reimbursement programs	• Most participants must attest that they completed up to 4 improvement activities for a minimum of 90 days. • Clinicians choose from 90+ activities under 9 subcategories: 1. Expanded Practice Access 2. Population Management 3. Care Coordination 4. Beneficiary Engagement 5. Patient Safety and Practice Assessment 6. Participation in APM 7. Achieving Health Equity 8. Integrating Behavioral and Mental Health 9. Emergency Preparedness and Response • **Note: Participation in the Michigan Surgical Quality Collaborative can help you satisfy the requirements of this category of MIPS.** • Different requirements apply for small groups, participants in rural or health professional shortage area, participants in patient-centered medical homes or MIPS-qualifying APMs (i.e., selected APMs that are not included in the subset of advanced APMs, like Medicare Shared Savings Track 1).

Performance Category and 2017 Category Weight	What Do I Need to Know? What are the Requirements?
 Advancing Care Information  	• Replaces Meaningful Use • Promotes patient engagement through electronic exchange of information using certified EHR technology • 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. OR You may not need to submit Advancing Care Information if these measures do not apply to you.
 Cost Not Included in 2017 (zero weight)	• Replaces Value-Based Modifier • No data submission required. Calculated from adjudicated Medicare claims.

How Can Eligible Clinicians Participate in MIPS?

Eligible clinicians can participate in MIPS as an:

Individual

Or

Group

A group, as defined by taxpayer identification number (TIN), would be assessed as a group practice across all four MIPS performance categories.

If you report MIPS data as an individual, (defined as a single National Provider Identifier tied to a single Tax Identification Number), you can send data to CMS via a certified electronic health record, qualified registry or qualified clinical data registry. Data for Improvement Activities and Advancing Care Information can also be communicated as an attestation.

If you report MIPS data as a group (defined as a set of clinicians, each with their own National Provider Identifier, but sharing a common Tax Identification Number), the group will get one payment adjustment based on the group's performance. A group can send group-level data for each of the performance categories to CMS via a certified electronic health record, qualified registry or qualified clinical data registry. A group can also submit data through a CMS web interface, but must register as a group for this option by June 30, 2017. Data for Improvement Activities and Advancing Care Information can also be communicated as an attestation.

How are Scores and Incentives Determined?

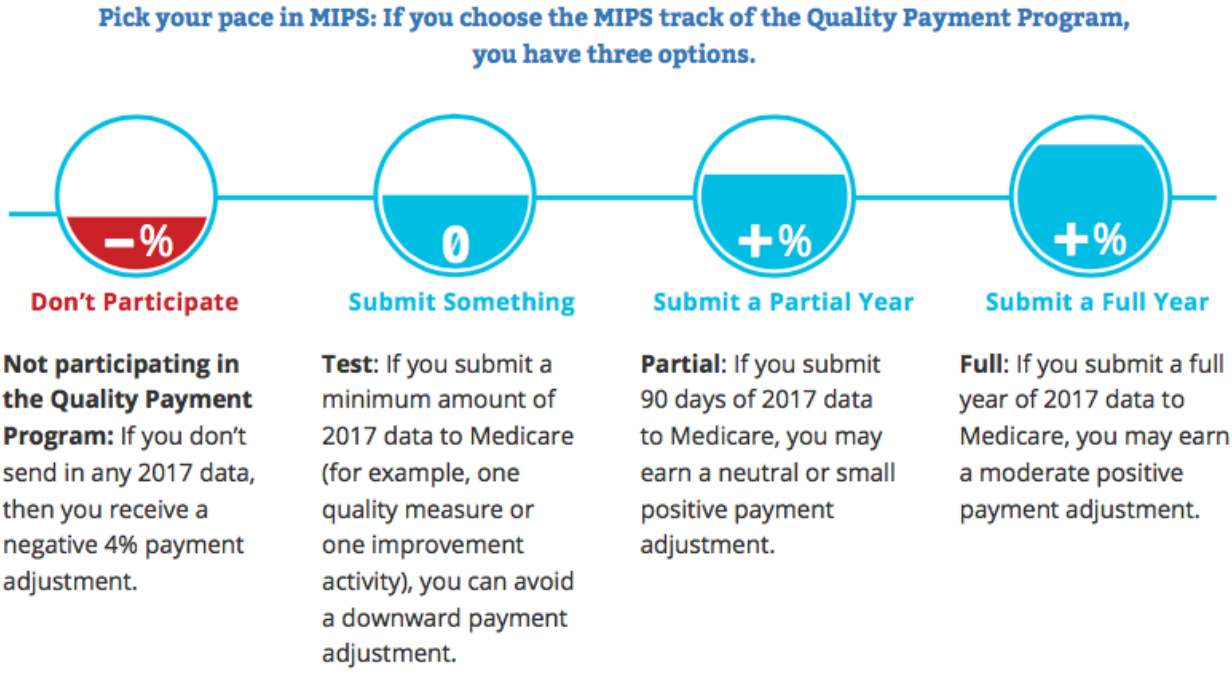
A single MIPS composite score will be calculated as the sum of the weighted performance in the four performance categories and reported using a 0 to 100-point scale. The composite score will be compared to MIPS performance thresholds to determine the payment adjustment percentage for the individual clinician or group of clinicians.

Performance in each category will be determined based on number of measures and points earned per measure. Points are earned based on performance in a measure compared to a benchmark or based on the degree to which the criteria for a specific measure have been satisfied. Also, bonus points are given in some categories for reporting certain types of "high value" measures.

What are the Timelines for Participation in MIPS?

Clinicians must collect data starting anytime between January 1 and October 2, 2017. You must submit the data by March 31, 2018 to avoid a payment penalty.

Your Medicare payments will be adjusted up, down or not at all, depending on the amount of data you submit and your performance results. The payment adjustments will be applied in 2019.



Payment adjustments will be between -4% and +4% in 2019 and will grow in subsequent years.