CARDIOVASCULAR MANAGEMENT OF ILLINOIS
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The more we know.....

MACRA 101 ESSENTIALS

READING MATERIALS

Part I	ACC "Frequently Asked Questions"
Part II	ACC "Medicare Access & CHP Reauthorization Act of 2015: What you need to know
Part III	ACC "CMS Proposes Structure for MACRA Implementation" --- The ACRONYMS
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MACRA: Frequently Asked Questions

What is MACRA? The *Medicare Access and CHIP Reauthorization Act of 2015,* commonly referred to as MACRA, introduces a new Medicare physician payment system. MACRA replaces the Sustainable Growth Rate (SGR) payment formula, establishes a framework for a quality-based system, streamlines current quality reporting programs into one system and reauthorizes two years of funding for the Children's Health Insurance Program. MACRA also creates stability for Medicare payments by mapping out payment updates for ten years and beyond – stability that was severely lacking under the SGR formula.

How Did We Get Here? For decades, under the flawed SGR system, a fee-for-service payment model meant that higher performing physicians had no ability to be rewarded for outcomes. Health care reform initiated a gradual transition from a volume-based payment system to one that incentivizes clinicians for providing quality care. The pinnacle of this transition was passage of MACRA into law, a culmination of over two years of close collaboration with members of Congress on both sides of the aisle and a broad array of stakeholders, including the ACC.

Medicare Payment and the SGR

How Are Clinicians Currently Paid Under Medicare?

Services provided by physicians and advanced practice professionals, such as physician assistants

and nurse practitioners, are billed to Medicare Part B. To determine the payment rates for these services, the Centers for Medicare and Medicaid Services (CMS) releases the annual Physician Fee Schedule. Each service is assigned relative value units (RVUs), which are based on the amount of work, time, practice expense and liability costs associated with that service. The RVUs are multiplied by the current year's conversion factor to arrive at the Medicare Part B payment rate to the clinician.

What Was the SGR?

The SGR formula was created by the *Balanced Budget Act of 1997* as a means to control Medicare spending by tying Medicare clinician payments to increases in the gross domestic product (GDP). When health care spending outpaced the GDP, this resulted in negative payment adjustments to the conversion factor. Congress passed 17 legislative patches to prevent cuts of over 20 percent from being implemented.

Why Was the SGR Flawed?

The SGR created a cycle of annual payment instability and uncertainty. Congress often worked until the final hour to pass legislation that would prevent large payment cuts resulting from the SGR from becoming reality. As a result, over the course of two decades, clinicians would come dangerously close to substantial payment cuts based on the flawed formula. This also sometimes created delays with claims processing as CMS and its contractors had to wait on whether or not the SGR cut would go into effect before finalizing annual payment updates in their systems. This cycle continued until MACRA was passed in 2015.

MACRA Structure

Who Does MACRA Impact? The new payment system has implications for physicians and advanced practice professionals, including physician assistants, nurse practitioners, and clinical nurse specialists in both practice and hospital settings.

How Is MACRA Structured? The Quality Payment Program, initiated by MACRA, is comprised of two pathways in which clinicians will participate in order to receive Medicare payment: The Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs). Most clinicians will participate in MIPS, which bundles the Physician Quality Reporting System (PQRS), the Value Modifier and the Electronic Health Record (EHR) Incentive Program into one program. Advanced APMs open up new methods of paying providers under Medicare.

How Will Physicians Be Measured? Regardless of which pathway a clinician participates in, he/she will be measured on four core components: Quality, resource use, clinical practice improvement and meaningful use of certified EHRs. In MIPS, these components make up the composite score. Advanced APMs are designed to incorporate these elements into the model framework.

When Will MACRA Be Implemented? Beginning July 1, 2015, clinicians began receiving a 0.5 percent payment increase to Medicare payments. This payment increase will continue annually until Dec. 31, 2018. Payment based on the two payment pathways of the MACRA Quality Payment Program (MIPS and APMs) will begin in 2019, based on 2017 performance. As the MIPS is implemented,

performance-based bonuses and penalties will be phased in, starting with a maximum incentive or bonus of 4 percent in 2019. Starting in 2026, annual payment updates will be determined by the eligible professional's participation in eligible APMs or traditional Medicare reimbursement linked to quality.

How Can I Prepare? As with many laws, MACRA is written with broad directions that will be implemented through more specific regulation by the federal agencies. On April 27, 2016, CMS **released a proposed rule** to implement MACRA, which introduced a plethora of acronyms and provisions and laid the groundwork for a final rule expected in fall 2016. Similar to the current reporting programs, MACRA does not require immediate data reporting; however, in order for clinicians to understand how their performance impacts their payments, it is important to understand the new system and begin preparations now. For most clinicians, this will mean evaluating your current PQRS, Value Modifier and EHR Incentive Program participation.

MIPS

What Is MIPS? MIPS is essentially a continuation of the current fee-for-service payment structure linked to quality. Clinicians will still be paid according to the Medicare Physician Fee Schedule amounts for their services. However, based on how they perform across four categories – quality reporting, resource use (cost), advancing care information (Meaningful Use of EHRs) and clinical practice improvement, practices will be eligible for bonuses or subject to penalties on their Part B payments.

Is MIPS Budget-Neutral? Yes, the MIPS program is budget neutral, meaning that bonuses will be funded by the penalties collected from clinicians performing below the set benchmark performance score. Those at or closer to the benchmark will see neutral payment or small incentives. These incentives will increase with the highest performers earning the highest bonuses. CMS has the authority to increase the bonus amounts to achieve budget neutrality or to incentivize higher performance. However, the maximum penalty amounts cannot be changed.

How Much Does Each MIPS Category Weigh? Starting with the 2019 payment period/2017 performance period, for most clinicians, 50 percent of the MIPS score will be based on quality, 25 on advancing care information (Meaningful Use), 15 percent on participation in clinical practice improvement activities, and 10 percent on resource use (cost).

When Does MIPS Begin? Based on the legislation and CMS' proposed rule, MIPS payment adjustments will be applied to payments starting on Jan 1, 2019. However, CMS proposes to base these adjustments on performance between Jan. 1, 2017, and Dec. 31, 2017.

Will I Participate in MIPS? CMS estimates that most cardiologists will participate in MIPS, at least in the initial years of MACRA implementation. If you are currently participating in PQRS and are not part of a Medicare Accountable Care Organization (ACO) or other CMS model reporting ACO-level quality measures, it is likely that you will participate in MIPS.

Will Anyone Be Exempt From MIPS? Yes, certain clinicians such as those seeing a low volume of Medicare beneficiaries and those participating in an Advanced APM may be exempt from MIPS reporting. Those meeting the Advanced APM exception may still be subject to reporting requirements under their model.

I Am in a Small Practice. Does MIPS Offer Any Flexibility For me? CMS proposes flexibility for small practices and those in rural or health professional shortage areas. For example, CMS proposes that these practices can participate in fewer clinical practice improvement activities and still achieve a full score in that category.

Where Can I Find the Rules on MACRA? The legislation (H.R. 2) was **passed and signed into law in April 2015**. CMS is currently in the process of creating the detailed policies and regulations implementing the law. The first **proposed policies** for the 2019 payment year/2017 performance year were released in the spring. Hundreds of individuals and organizations, including the ACC, submitted **comments** on the proposed policies. CMS will consider the stakeholder feedback and finalize the first set of policies by Nov. 1, 2016. As with the current quality programs, CMS will engage in additional rulemaking to continue to implement and refine MIPS. As the implementation timeline progresses, CMS will continue to issue additional policies and the ACC will continue to engage CMS in discussions on how to implement policies that best support quality cardiovascular care.

How Can I Prepare For MIPS Participation? The first step to preparing for MIPS is to figure out how you and your practice are currently participating in the **Medicare quality reporting programs** (PQRS,

the Value Modifier and the EHR Incentive Program.) You may be able to obtain this information through your practice administrators or hospital administrators. If you are successful in these current programs, you may be well positioned to transition to MIPS.

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Medicare Access and CHIP Reauthorization Act of 2015: What You Need to Know

May 26, 2015

Heart of Health Policy | In April, President Barack Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which permanently repeals the Sustainable Growth Rate (SGR), establishes a framework for rewarding clinicians for value over volume, streamlines quality reporting programs into one system and reauthorizes two years of funding for the Children's Health Insurance Program (CHIP).

MACRA's passage into law is a culmination of over two years of close collaboration with members of Congress on both sides of the aisle and a broad array of stakeholders, including the ACC. The law touches upon many areas across the health care spectrum.

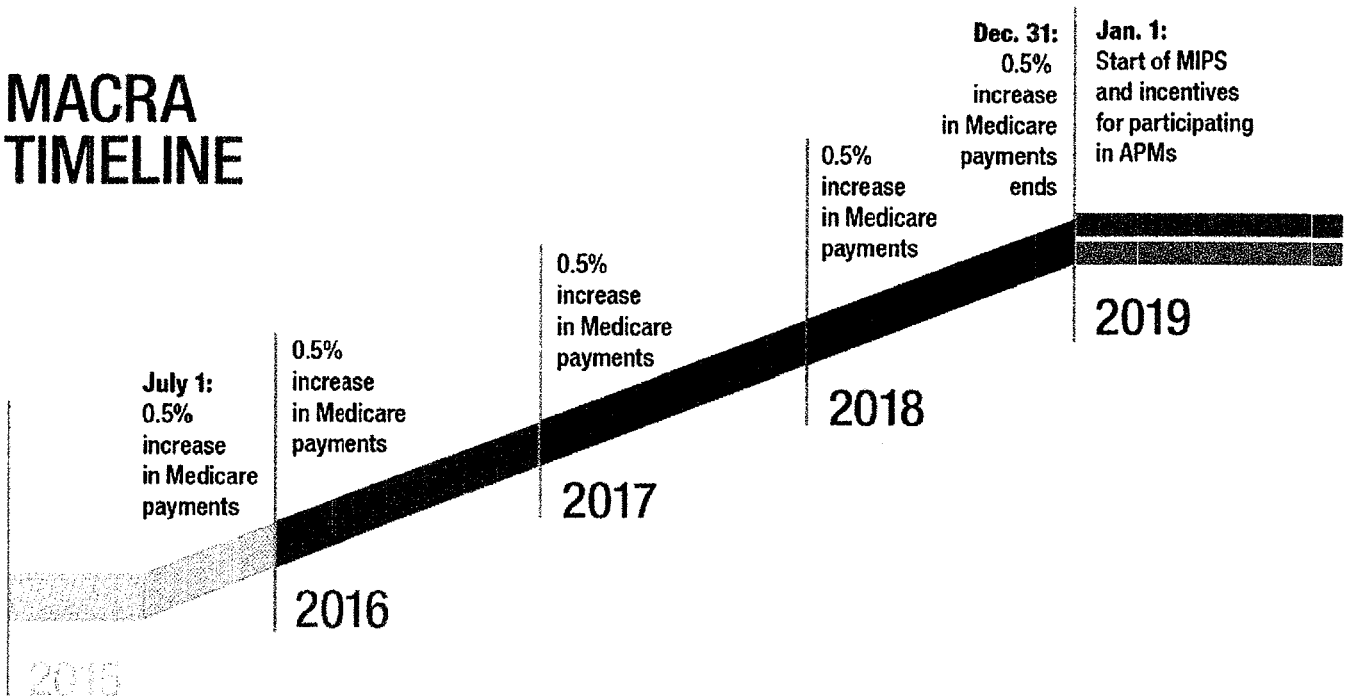
As with any law, the language of MACRA is drafted with a high degree of flexibility to allow medical specialty organizations like the ACC to work closely with the Department of Health and Human Services (HHS) through the regulatory process to establish how the law will function. The passage of the law represents only the first step in a long process, albeit an important one.

MACRA Timeline

Beginning July 1, clinicians will begin receiving a 0.5 percent increase to Medicare payments. This payment increase will continue annually until Dec. 31, 2018. Starting in 2019, clinicians will choose from one of two pathways: the Merit-Based Incentive Payment System (MIPS) or Alternative Payment Models (APMs).

What MACRA Does

- Repeals the flawed SGR formula used for determining Medicare payments to clinicians. The SGR henceforth does not exist.
- Establishes a period of positive payment increases by providing an annual 0.5



percent payment increases for clinicians to support a predictable transition from fee-for-service to quality-based payment.

- Promotes the transition to quality-based payment by implementing two payment pathways for clinicians beginning in 2019: the new MIPS or an APM.
- Supports participation in APMs by providing annual payment increases of 0.75 percent to those participating in a qualifying APM in 2026 and beyond, and 0.25 annual payment increases to all other clinicians.

Other provisions included in MACRA include:

- Reauthorization of funding for CHIP for two years through fiscal year 2017.
- Delayed enforcement of the "two-midnight" rule until Oct. 1. Until then, contractors may only review claims to probe and educate, and claims submitted before Oct. 1 will not be subject to post-payment reviews by Recovery Audit Contractors. The "two-midnight" rule required patients spend at least two nights in the hospital to be considered inpatient for reimbursement purposes.
- Prohibition of implementation of 2015 Medicare Physician Fee Schedule provisions requiring the transition of all 10-day and 90-day global surgical packages to 0-day global periods.
- Expansion of the use of Medicare data for transparency and quality improvement by removing barriers and allowing for Medicare data to be provided to qualified clinical data registries to facilitate quality improvement.

- Requirements that the HHS Secretary draft a plan for development of quality measures to assess professionals, including non-patient-facing professionals.
- Declaration of a national objective to achieve widespread exchange of health information through interoperable certified electronic health record technology nationwide by Dec. 31, 2018.
- Provision to protect clinicians by preventing quality program standards and measures (such as PQRS/MIPS) from being used as a standard or duty of care in medical liability cases.

Learn more about how this legislation will impact you and your practice on *ACC.org.*

Keywords: *Cardiology Magazine, ACC Publications, Cooperative Behavior, Electronic Health Records, Fee Schedules, Fee-for-Service Plans, Liability, Legal, Medicare, Quality Improvement, Registries, United States Dept. of Health and Human Services*

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CMS Proposes Structure For MACRA Implementation

Apr 27, 2016

The Centers for Medicare and Medicaid Services (CMS) released **proposed regulations** ☞ on April 27 to implement the _____ _____ **(MACRA)** ☞. These regulations will establish rules for clinician participation in both the Merit-Based Incentive Payment System (MIPS) and qualifying for incentive payments based on participation in Advanced Alternative Payment Models (APMs) beginning with the 2019 payment year. Initial highlights include:

MIPS

- MIPS will streamline the existing Physician Quality Reporting System, Value-Based Modifier, and Meaningful Use (MU) programs into a single program that introduces a fourth component of clinical practice improvement activity (CPIA) participation. MIPS payment adjustments of up to +/-4 percent in 2019 will be based on a clinician's composite performance score (CPS) in the following categories in the 2017 performance year (Jan. 1 - Dec. 31):
  - *Quality* (50 percent of CPS): Most MIPS eligible clinicians will be required to report at least six measures, including at least one cross-cutting measure and one outcome measure.
  - *Advancing Care Information* (25 percent of CPS): Formerly recognized as MU, clinicians will report on measures focusing on interoperability and the use of technology to facilitate information exchange. Unlike the current Electronic Health Record (EHR) Incentive Program, there is no all-or-nothing EHR measurement or requirement to report additional quality measures. However, no changes will be made to the 2016 reporting requirements for the EHR Incentive Program.
  - *Clinical Practice Improvement Activities* (15 percent of CPS): CMS proposes that clinicians participate in CPIAs for a minimum of 90 days, with points assigned to over 90 activities, including participation in clinical data registries. While CMS proposes not to require a minimum number of

activities to meet this requirement, the Agency does propose a score of 60 points to achieve full credit.
    - *Resource Use* (10 percent of CPS): CMS proposes to continue two measures from the current **Value-Based Payment Modifier**; total costs per capita for all attributed beneficiaries and the Medicare Spending per Beneficiary measure, with adjustments. In addition, applicable clinical episode-based measures will apply. Resource use data will be pulled from Medicare claims data and require no reporting by clinicians.
- MIPS eligible clinicians will have the option to report as individuals, as a group practice or as an APM entity.
- Beginning July 1, 2017, CMS proposes to provide clinicians with performance feedback on the quality and resource use categories of MIPS.

APMs

- CMS defines criteria by which an APM entity can demonstrate that it meets the definition of an Advanced APM. CMS will post a list of qualifying Advanced APMs through which Qualifying Participants (QPs) can earn bonus payments prior to each performance period, starting no later than Jan. 1, 2017.
- Most Advanced APMs will have to meet thresholds for marginal risk (>30 percent), minimum loss ratio (>4 percent), and total potential risk (calculated for each APM) to satisfy the law's "more than nominal" risk requirement. The first performance year for QPs in Advanced APMs will be 2017. QPs who obtain enough payments or patients through the Advanced APM will be eligible for a 5 percent lump sum Advanced APM Incentive Payment from 2019 through 2024 with higher fee schedule updates starting in 2026.
- For 2019, performance will be based on participation in Medicare Advanced APMs. Starting in 2021, CMS will recognize the All-Payer Combination Option which allows clinicians to meet the participation threshold via Medicare Advanced APMs and/or Other Payer Advanced APMs.
- CMS proposes a process for Advanced APM participants who do not meet the QP threshold and are considered "partial QPs" to choose whether or not to be subject to the MIPS payment adjustment.
- CMS proposes to define a "physician-focused payment model" (PFPM) as "an Alternative Payment Model wherein Medicare is a payer, which includes physician group practices or individual physicians as APM Entities and targets the quality and costs of physician services." PFPMs would be required to be designed with Medicare as a payer.

Get up to speed on the background of the law and continue to watch for new updates on the ACC's **MACRA Information Hub**. The proposed regulations are open for public comment for 60 days. Additional information will be forthcoming as your ACC, committees and councils review and analyze the proposals. The College will submit comments that support members' ability to succeed in the programs through the delivery of high quality cardiovascular care.

Keywords: *Access to Information, Centers for Medicare and Medicaid Services (U.S.), Electronic Health Records, Fee Schedules, Mandatory Reporting, Meaningful Use, Medicaid, Medicare, Outcome Assessment (Health Care), Registries*

Suggested Materials

- **MACRA Information Hub**

How will the Quality Payment Program affect me?

Am I in an **APM**?

✓ **Yes** **No**

Am I in an **Advanced** APM?

✓ **Yes** **No**

Do I have **enough payments or patients** through my Advanced APM?

Yes **No**

Qualifying APM Participant (QP)

- **Excluded** from MIPS
- 5% lump sum **bonus payment** (2019-2024), higher **fee schedule updates** (2026+)
- APM-specific **rewards**

Favorable MIPS scoring & APM-specific **rewards**

Is this my **first year** in Medicare OR am I below the **low-volume threshold**?

Yes **No**

Not subject to **MIPS**

Subject to **MIPS**

Bottom line: There will be **financial incentives for participating in an APM**, even if you don't become a **QP**.

Big Decisions

MACRA pushes the value agenda and forces physicians to choose how they get paid.

BY RYAN GRAVER, CATHIE BIGA, AND KELSEY REICHERT

The road to health care transformation is anything but smooth—it continues to wind, split, and dip in new and unexpected ways. It won't be enough to simply buckle up for the very bumpy ride; physicians and organizations that want to thrive in the value-based world need to prepare for the trip now—research the best route to take, weigh the options, plan for detours, anticipate the unknown, and keep a GPS handy. One of the latest examples of the ever-changing health care landscape is MACRA, the Medicare Access and CHIP Reauthorization Act of 2015, which was signed into law on April 16th as the fix for the sustainable growth rate (SGR). It is, however, much bigger than that. The real impact of MACRA will be its role as the road map for the implementation of a value agenda. Although many details about MACRA are yet to be determined, it will (in absolute terms) force a migration away from fee-for-service reimbursement and push health care toward its goal of achieving the triple aim of high-quality, low-cost care with an exceptional patient experience. MACRA advances the movement away from payment for volume and replaces it with a system that ties payment to mandates for quality, outcomes, and efficient care; it achieves this with the introduction of the merit-based incentive payment system (MIPS) and the alternative payment models (APMs) (Figure 1).

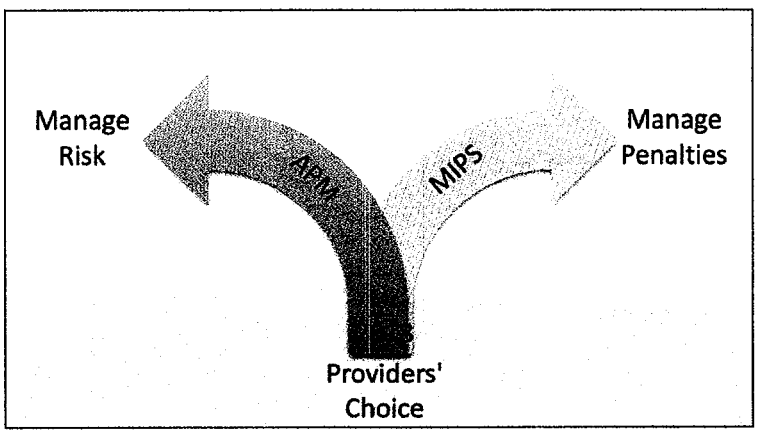

Figure 1. The reimbursement decision for providers.

THE VALUE AGENDA

MACRA is largely focused on furthering the value agenda under the Affordable Care Act. The initiatives that were created by the current value-based modifier program (also known as physician value-based purchasing program), along with the *physician quality reporting system* (PQRS) and Meaningful Use, will sunset on December 31, 2018. After that, physicians will be faced with deciding between following the guidelines for participating in MIPS or choosing to be in an APM. Both options pose financial risk to reimbursement if preset quality measures and savings goals are not met. Regardless of which program a physician chooses, MACRA is pushing physicians to focus on delivering value, not just providing services for patients.

MIPS

Although many unknowns continue to persist, MACRA does outline that MIPS will be one of two pathways that physicians may choose in terms of how they will be paid. It is believed that MIPS will embrace many of the current quality elements, while developing a new methodology to assess performance in order to create a performance score to use for calculating payment incentives and penalties. Beginning in 2019, physicians will choose from an annual list of quality measures to report (somewhat similar to the current PQRS). After 2 years, other eligible providers, such as advanced practice providers (APPs), social workers, and occupational therapists can be added. Physicians need to be aware that individual program penalties will continue through 2018, and data collected in the coming years will be used for the MIPS incentive payments starting in 2017 (2 years after the year of performance).

The MIPS program will be divided into four main categories: quality, resource use, meaningful use, and clinical practice improvement (Figure 2). Each category is scored and then combined to create a total score from 0 to 100, weighted on differing levels. Quality will account for 30% of the score, resource use will be 30%, clinical practice improvement will be 15%, and mean-

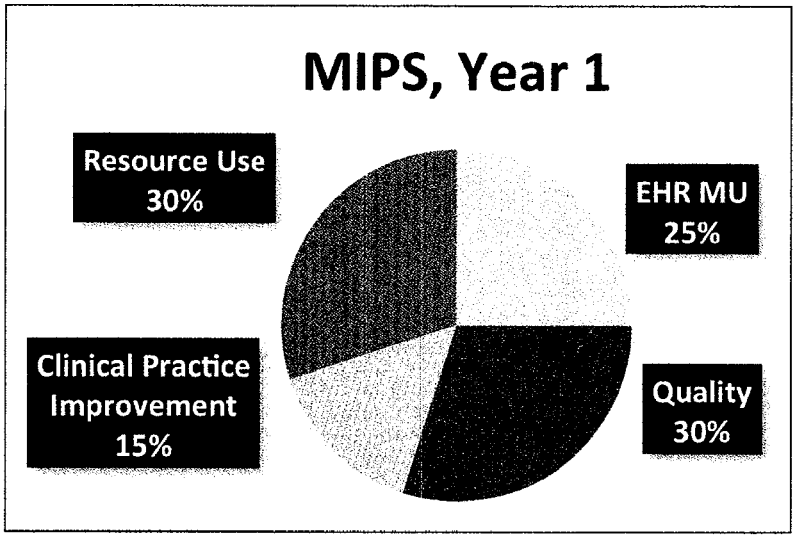

Figure 2. Performance score breakdown.

ingful use will be 25%. It is noted in this original Bill that these may be adjusted. Each eligible provider will receive a composite performance score based on these categories, which will determine the reimbursement for that specific year. It is interesting to note that although there will be a "group" measure, unlike the value modifier program, MIPS will be based on individual National Provider Identifier numbers.

What are these categories based on? The quality portion of the score may be based on measures currently used in the value programs. Resource use will rely on data similar to the value-based modifier, but with some significant changes (such as including Part D drug information). This category does allow for attribution and risk-adjustment methodology. It is intended that meaningful use measures will continue to be utilized to create the scoring for the category. Finally, clinical practice improvement will be based on access, population management, care coordination, beneficiary engagement, patient safety, and practice assessment. This critical component of MACRA is intended to get the Medicare beneficiary actively involved in their care.

How will your score affect your payment adjustments? Physicians will be placed into three categories based on where their score lands against the decided threshold. If physicians are below the threshold, they will receive negative payment adjustments starting at 4% in 2019, and slowly increase as shown in Table 1. Neutral adjustments will be made for those who reach the threshold. For physicians above the threshold, there will be the opportunity to gain positive adjustments for a maximum of up to three times the annual cap for negative adjustments. It should be noted that benchmarks are set on the previous year's data for a performance period. This will necessitate better data turnaround times than are currently experienced.

APM

On January 26, 2015, Health & Human Services announced measurable goals and a timeline for shifting Medicare from the traditional fee-for-service system to one that pays on the basis of quality of care and outcomes, or a "value-based" payment system. The Centers for Medicare & Medicaid Services (CMS) pandor called for a specific, year-by-year increase in the percentage of Medicare payments that are value based. According to the schedule, by the end of 2016 at least 30% of traditional, or fee-for-service, Medicare payments will be tied to quality or value through alternative payment models, such as accountable care organizations (ACOs) or bundled payment arrangements. By the end of 2018, that value will be 50%. The goals also include tying 85% of all traditional Medicare payments to quality or value

TABLE 1. THRESHOLDS FOR NEGATIVE AND POSITIVE ADJUSTMENTS

Performance Year	Payment Year	Maximum Negative Adjustment	Maximum Positive Adjustment
2017	2019	-4%	12%
2018	2020	-5%	15%
2019	2021	-7%	21%
2020	2022	-9%	27%

by 2016 (and 90% by the end of 2018) through programs such as the hospital value-based purchase and hospital readmissions reduction programs.[1]

MACRA has further provided clarity to the means by which CMS will achieve these stated goals. MACRA included four models that would be available for those choosing the APM pathway. The first model must come from CMS Innovation, but cannot be one that has received an innovation award. Second, is the Medicare shared savings program—similar to the current methodology. The final two are "yet to be determined" and will be based on demonstration projects approved under Section 1866C SSA, or a demonstration model that is required by federal law. There are certain core requirements for the APM pathway, which include the mandate to use certified electronic health records (EHRs) and a process that pays for services based on quality measures, while bearing some financial risk. It is believed that 60% of physicians will be in an ACO by 2019, and all physicians will be part of an ACO by 2038. With this in mind, MACRA seems to be pushing physicians to adopt an APM model.

Participation in an APM must follow one of two routes. The first option is to track the amount of revenue received from Medicare APM payments. To qualify, 25% of a provider's revenue must come from a Medicare APM in 2019 and 2020. In 2021 and 2022, 50% of revenue needs to come from a Medicare APM. The second track states that 50% or more of revenue must come from an APM with Medicare, or APM payments from other payors by 2021 and 2022. Physicians electing to participate in APMs will be exempt from MIPS and most meaningful use requirements. In addition, from 2019 to 2024, providers qualifying for the APM track will receive a 5% annual lump sum bonus on their Medicare Physician Fee Schedule payments from the preceding year. This percentage will increase annually. The APM option under the value agenda for MACRA may come with more financial risk, but it has potential to offer the greatest financial reward.

MAKING AN INFORMED DECISION (OR PUTTING YOUR MONEY WHERE YOUR MOUTH IS)

What is known for sure is that MACRA creates a value agenda to steer physicians toward advancing quality improvement initiatives and cost-cutting efforts. The time to wait and see what happens is over. CMS is the country's single largest payor, and it is leading our rapid advance to transformation. There are still many questions to be answered and details to be worked out. This is good news—it means that physician understanding of and involvement with MACRA as it develops can influence appropriate structure and implementation. Now is the time to get involved; MACRA states the Secretary of Health and Human Services and key stakeholders must develop and publish a plan for MIPS and APM development by May 2016.

> Physicians will be faced with deciding between following the guidelines for participating in MIPS or choosing to be in an APM; both options pose financial risk to reimbursement.

The big question for physicians: how do you want to be paid? What are the pros and cons of penalty-based payment versus population risk-based payment? How will physicians be measured and benchmarked? Are your practices and service lines ready for what comes with each track? What will the impact be—for health care systems and the communities they serve? What is the best way to achieve high-quality health care at lower costs? As providers, are you leading the transformation of your care delivery to be successful in this new normal of health care?

Success in the evolving value-based world requires understanding of the nuances of programs like MACRA that are pushing the industry forward. Being involved with the process, networking with peers, talking with experts, and having a voice in how MACRA develops will help each physician make smarter and more sustainable choices. ■

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1. Better care. Smarter spending. Healthier people: paying providers for value, not volume. Centers for Medicare & Medicaid Services Web site. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html. Accessed August 10, 2015.