

**The MACRA Impact:
Anticipated Challenges of Solo & Small Practices**

**National Briefing Webinar
Thursday, July 28, 2016**

Announcements

- MACRA comments submitted last month:
 - Because MACRA plays such an important role in payment reform, we published a detailed [webpage on MACRA](#) and hosted 2 [National Briefing webinars](#).
 - Our [official MACRA comment letter](#)
 - We also issued a [press release](#), and did several media interviews with trade publications.
- Mark your calendars for our [2016 Annual Fall Conference](#) – Nov. 9-11 in Washington DC. It's our 10th Anniversary and will be a memorable celebration you won't want to miss! Check our conference website, [pcpccevents.com](#), for details!
 - [Sponsorship opportunities](#) are available to highlight your company or organization among the “movers and shakers” in advanced primary care.
- Join us! Primary Care is the hot topic right now in health care policy circles and beyond. Want to join the movement? Executive membership in our Collaborative offers many valuable benefits to organizations large and small. If you'd like to learn more, please visit [pcpcc.org/executive-membership](#) or contact Amanda Holt on our team.
- No briefing next month (August).

Introducing...



Travis Broome, MBA, MPH
Policy Lead & Executive Director
Aledade, Inc.





Navigating MACRA:

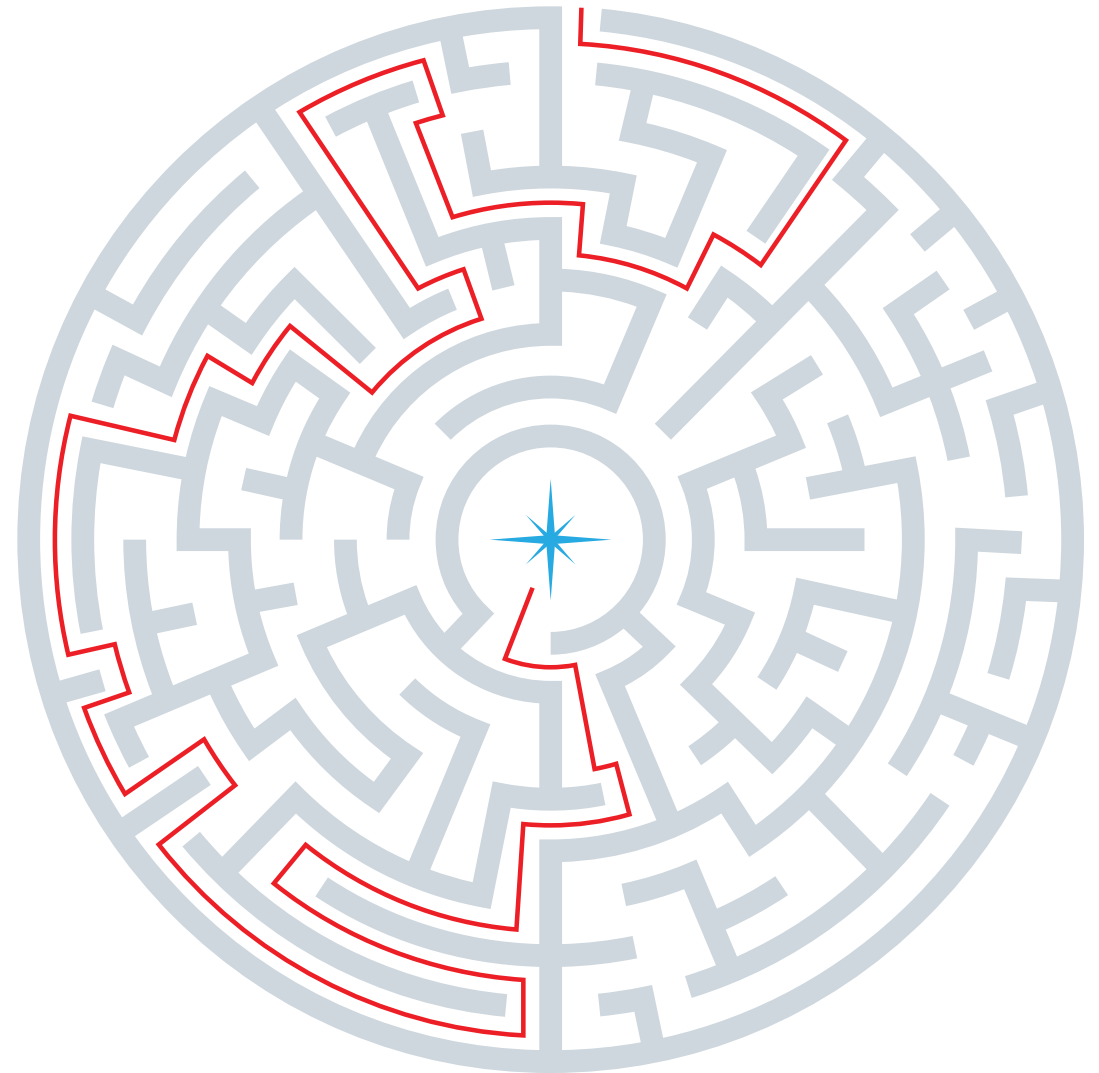
Small and Solo Practices

JULY 2016



MACRA is a complex piece of legislation. This slide deck is designed to help you find your path. It will help you answer:

- What is MACRA?
- How does MACRA change your payments and reporting requirements for small and solo practices?
- What does MACRA mean for your practice?





Introduction to MACRA



Medicare Before and After MACRA



Medicare's Proposed 2-Track Payment System



Timeline of Medicare Changes



Implications for Your Practice

Definition:

The **Medicare Access and Reauthorization Act of 2015 (MACRA)** is a law that reforms the Medicare payment system for physicians. MACRA shifts Medicare to a value based system, tying your Medicare payments to cost and quality performance.

MACRA changes Medicare payments in 4 ways:

- Repeals the current, flawed sustainable growth rate (SGR) methodology or “the doc fix”
- Sets extremely modest baseline increases to your Medicare payments over 10+ years
- Consolidates current fee-for-service programs (Meaningful Use, Physician Quality Reporting System, and Value-Based Payment Modifier) into a single, fee-for-service based value program (MIPS)
- Creates a new, completely separate alternative payment track for physicians participating in Advanced Alternative Payment Models (AAPMs)



No more
“Doc Fix”

MACRA repeals SGR, ends current fee-for-service programs, and introduces a **2-track payment system**

	Before MACRA	After MACRA
	Pre – 2019	2019 & Beyond
Core Payment Methodology	<ul style="list-style-type: none"> Physician Fee Schedule (PFS) Sustainable Growth Rate (SGR) 	<ul style="list-style-type: none"> Modest increases to PFS, starting in 2016 Repeal of SGR
Reporting & Incentive Programs	<ul style="list-style-type: none"> Meaningful Use (MU) Physician Quality Reporting System (PQRS) Value Based Payment Modifier (VM) 	<ul style="list-style-type: none"> Replacement of current fee-for-service programs (MU, PQRS, VM) with a 2-track payment system: <ol style="list-style-type: none"> Merit-Based Incentive Payment System (MIPS) Advanced Alternative Payment Models (AAPMs)
Description of Programs	<i>See Appendix for description of SGR, MU, PQRS, VM</i>	<i>See following slides for description of MIPS and AAPMs</i>
Requirements for Practices	<ul style="list-style-type: none"> Attest to Meaningful Use Report practice metrics for PQRS 	<ul style="list-style-type: none"> Report practice metrics for MIPS (if applicable)* Report practice metrics for AAPMs (if applicable)*

*Reporting requirements are subject to change in final CMS rule

Track 1
Merit-Based
Incentive System
(MIPS)

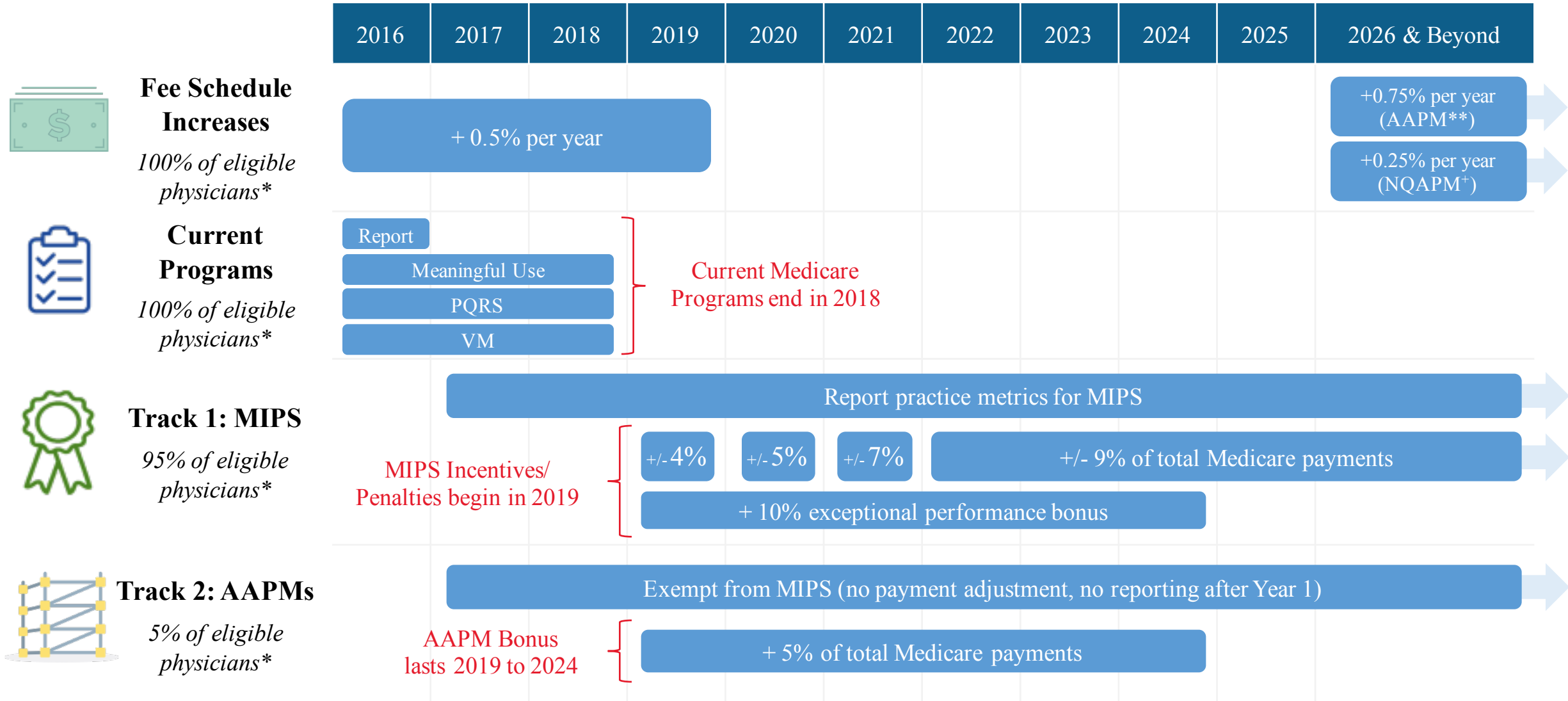
95%
of physicians*

Track 2
Advanced Alternative
Payment Models
(AAPMs)

5%
of physicians*

*Percentage of physicians in each payment track estimated by CMS

Timeline of Medicare Changes



*Fee schedule and current programs apply to physicians participating in Medicare; MIPS and Advanced APMs apply to eligible physicians with sufficient Medicare volume

**Physicians in Qualifying APMs (i.e., AAPM) receive a fee schedule increase of 0.75% per year, starting in 2026

†Physicians not in Qualifying APMs (NQAPM) receive a fee schedule increase of 0.25% per year, starting in 2026

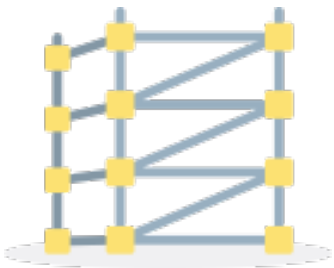
Nearly all physicians with Medicare patients will be paid through one of these tracks:

Likely Payment Track for Your Practice



Track 1: Merit-Based Incentive Payment System (MIPS)

- Medicare's default payment track, starting in 2019 (performance period begins 2017)
- Practices are scored across quality, cost, EHR, and practice improvement measures
- A composite performance score (CPS) sets annual incentives / penalties*
- Exceptional performers can receive up to 10% in bonus payments from 2019 to 2024*




Track 2: Advanced Alternative Payment Models (AAPMs)

- Practices in an Advanced APM are exempt from MIPS incentives / penalties
- These practices are also exempt from MIPS reporting requirements
- Practices receive a 5% annual payment bonus from 2019 to 2024

*Details of composite performance score and bonus amount for exceptional performers are subject to change in final CMS rule

MIPS will replace 3 current Medicare reporting and incentive programs:

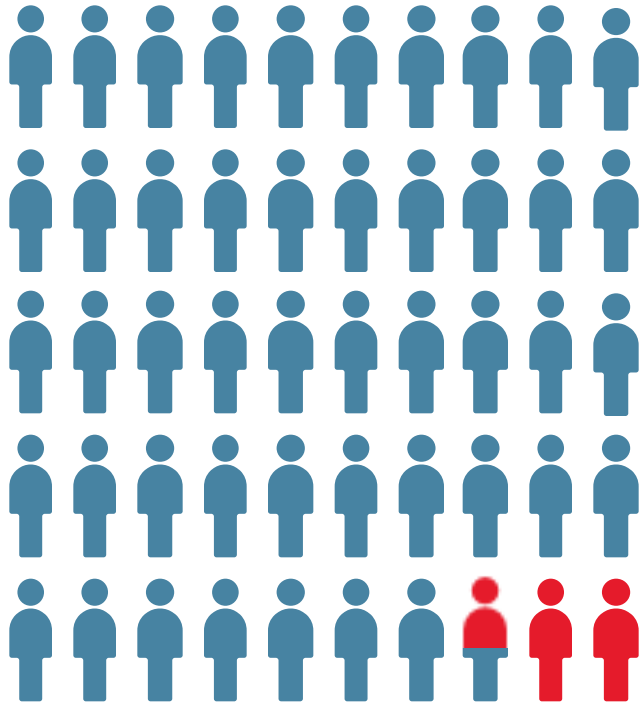
- 1. Meaningful Use (MU)**
- 2. Physician Quality Reporting System (PQRS)**
- 3. Value Based Payment Modifier (VM)**

A large blue bracket on the right side of the slide, grouping the three items in the list above.

For more information on these programs, see the Appendix

Your practice is subject to MIPS unless you fall into one of 3 exemption categories:

MIPS applies to ~95% of the physicians in the U.S.*



Physician Exemptions from MIPS⁺

- 1. New Medicare Physicians:** this is your first year receiving payments from Medicare
- 2. Low Volume Medicare Physicians:** you have Medicare billing charges of <\$10,000 per year and you provide care for 100 or fewer Medicare patients per year
- 3. Qualified Participants in Advanced APMs:** you participate in an Advanced Alternative Payment Model, such as:
 - Medicare Shared Savings Program – two-sided risk
 - Comprehensive Primary Care Plus
 - Next Generation ACO Model

*Percentage of physicians in MIPS estimated by CMS

⁺Criteria for physician exemptions are subject to change in final CMS rule

Under MIPS, your practice faces 3 changes to Medicare payments:

1

Fee Schedule Increases

- Baseline increases of 0.5% per year to your Medicare payments from 2016 to 2019
- Baseline increases of 0.25% per year to your Medicare payments, starting in 2026*

2

MIPS Incentives / Penalties

- Annual positive/negative adjustments to your Medicare payments, based on your MIPS composite performance score (new scoring index, starting in 2017)
- Scheduled increases in incentives / penalties over time:

2019: +/- 4% of Medicare payments	2021: +/- 7% of Medicare payments
2020: +/- 5% of Medicare payments	2022: +/- 9% of Medicare payments

3

MIPS Exceptional Performance Bonus

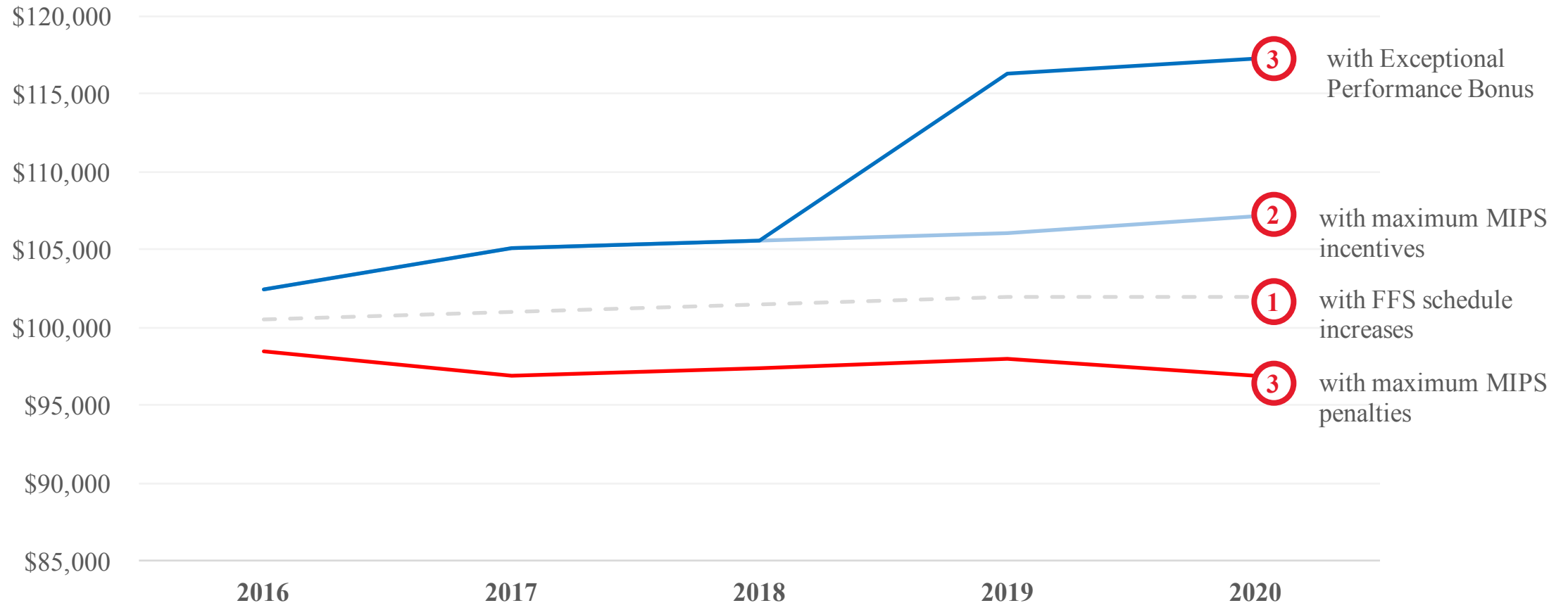
- Applies if your practice scores above the “exceptional performance” threshold on the MIPS scoring index (threshold to be determined)
- Potential bonus of 10% of Medicare payments per year from 2019-2024⁺

*Assumes no participation in an Advanced Alternative Payment Model (APM)

⁺Amount for exceptional performance bonus subject to change in final CMS rule

These changes will create wide variation in revenue for the same set of Medicare services:

Example: Projected Medicare Payments on \$100K Business Today



Your practice's penalties / incentives will be based on a new composite performance score:

MIPS Composite Performance Score (CPS) Category	Score Weighting	
	2017*	MSSP**
 Quality <i>(PQRS Style Measures)</i>	50%	50%
 Clinical Practice Improvement Activities <i>(Practice Processes)</i>	15%	20%
 Advancing Care Information <i>(Rebranded Meaningful Use)</i>	25%	30%
 Resource Use <i>(Total Patient Costs)</i>	10%	N/A ⁺





- First year of MIPS scoring emphasizes quality metrics*
- Practices in non-Advanced APMs (e.g., Medicare Shared Savings – Track 1) are not scored on costs
- **Performance period begins in 2017 and sets your incentives/penalties for 2019****
- **Failure to report = maximum penalties**

*Weighting will shift over time, with Quality and Resource Use both weighted at 30% by 2019

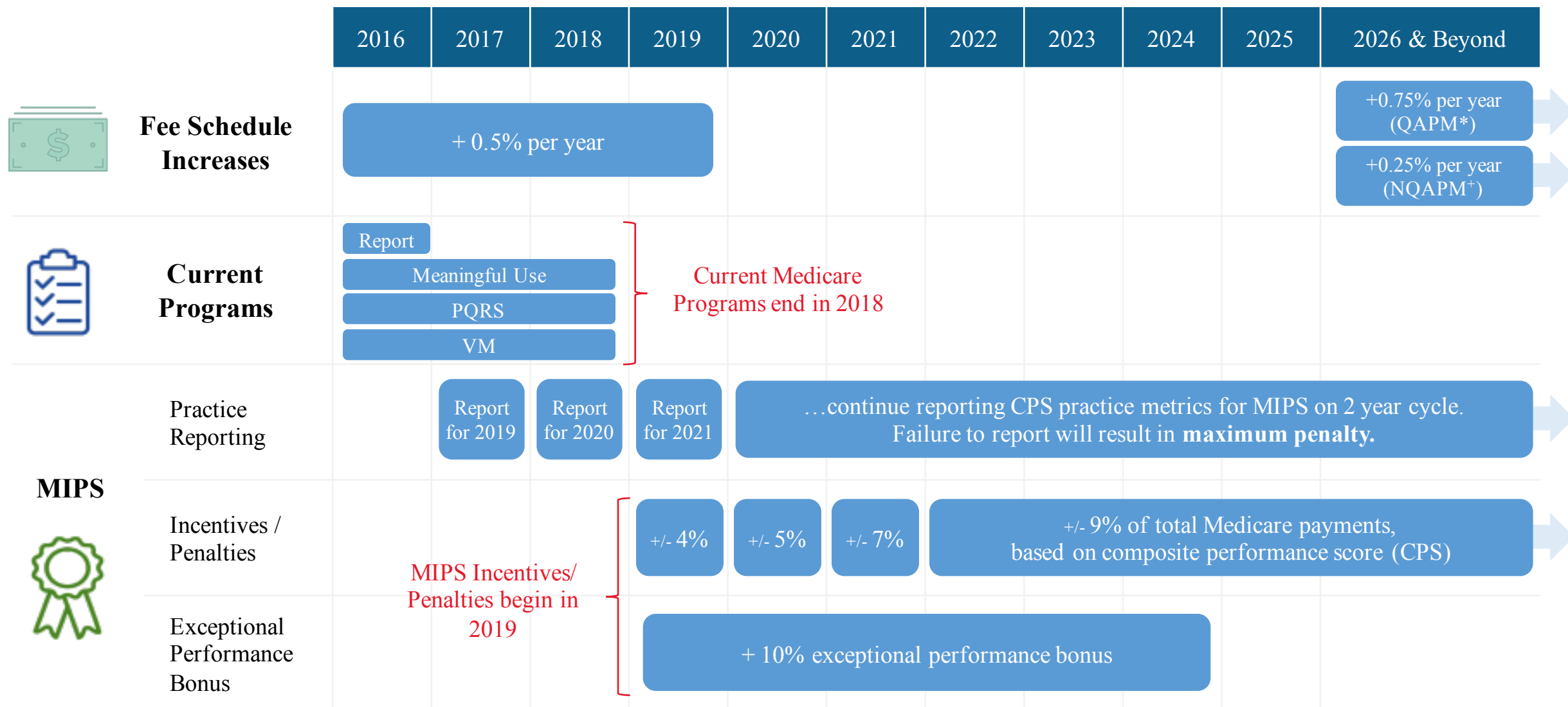
⁺Participants in the Medicare Shared Savings Program – Track 1 are exempt from cost scoring in the proposed rule

**Start date of performance period and weighting of MSSP are subject to change in final CMS rule

Starting next year, your practice must submit detailed reporting measures for this score:

CPS Category	Reporting Requirements for Practices*	Submission Method*
 Quality	<ul style="list-style-type: none"> • Pick 6 out of 100 measures to report (PQRS/MU eQuality) • Must report 1+ outcome measure (e.g., HbA1c poor control) 	<ul style="list-style-type: none"> • Claims • GPRO • Registries (Bonus Points) • EHR Submission (Bonus Points)
 Clinical Practice Improvement Activities	<ul style="list-style-type: none"> • Pick from menu of 90+ activities with different weights • All activities weighted 10 points or 20 points • Need 60 points for full credit 	<ul style="list-style-type: none"> • Attestation • Exploring EHR and Registry Submission • Can be reported at group level
 Advancing Care Information	<p>12 Total Measures in 3 Categories (11 Required)</p> <ul style="list-style-type: none"> • Need 100 out of 131 possible points • 50 points for reporting all 11 measures • 80 possible points for performance on 8 measures • 1 bonus point for reporting the 12th measure 	<ul style="list-style-type: none"> • Same as Clinical Practice Improvement Activities
 Resource Use	<ul style="list-style-type: none"> • No practice reporting required (calculated from claims) 	<p>N/A</p>

Details subject to change in final CMS rule (published Nov 2016)



*Physicians in Qualifying APMs (QAPM) receive a fee schedule increase of 0.75% per year, starting in 2026

+Physicians not in Qualifying APMs (NQAPM) receive a fee schedule increase of 0.25% per year, starting in 2026

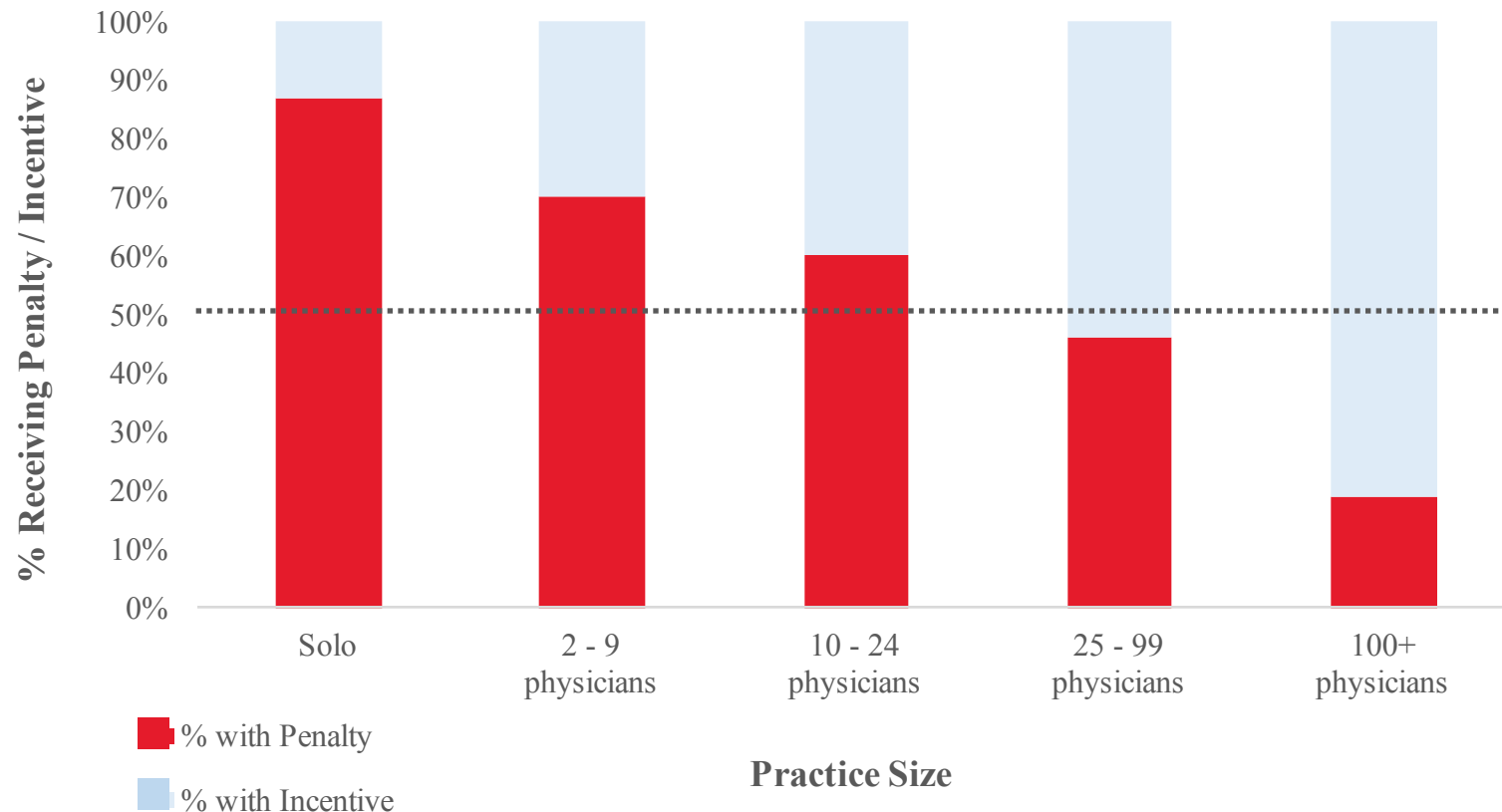
**Timing of reporting requirements subject to change in final CMS rule



Medicare Payments at Risk

Most small practices will likely be penalized by CMS in 2019*:

Estimated Impact to Practices from MIPS (2019)*



- Due to the burden of new reporting requirements, most small practices are expected to be penalized by CMS in 2019*:
 - 87% of solo practices
 - 70% of practices with 2 - 9 physicians
- In contrast, the majority of large practices (25+ physicians) are expected to receive incentives

*Estimates based on assessment from the CMS Office of the Actuary, posted in Table 64 of the MIPS proposed rule

MIPS impacts your practice in several ways:



Medicare Payments at Risk

- A growing share of your Medicare payments are at risk
- Your cost and quality performance will lead to penalties or incentives



New Reporting Requirements

- Under MIPS, your practice must report quality, EHR use, and practice improvement information
- Failing to report leads to maximum penalties
- How well equipped are you to report quality and meaningful use and to take on additional reporting



Key Decision to Join Up or Go Alone





- MACRA encourages practices to join Alternative Payment Models (APMs)
- MACRA also created “virtual groups” which allow practices to be treated as a group for scoring yet retain complete independence
- Going it alone – the MACRA proposed rule does not account for practice size the way the Value Based Modifier does



Preparing for Value Based Care

- MIPS is not the last change to Medicare
- Decisions should include strategic decision making on not just MIPS or even just Medicare but all payer initiatives

If you participate in an ACO (e.g., MSSP – Track 1*), MIPS looks different:

CPS Category	Advantages for Practices in MSSP - Track 1*
 <p>Quality</p>	<ul style="list-style-type: none"> • No reporting required from practices (ACO submits on behalf of practices through GPRO) • ACO’s quality measures replace MIPS measures
 <p>Clinical Practice Improvement Activities</p>	<ul style="list-style-type: none"> • Same overall requirements (60 points = full credit) • Practice gets 30 points automatically for being in MSSP
 <p>Advancing Care Information</p>	<ul style="list-style-type: none"> • None (same requirements and submission method)
 <p>Resource Use</p>	<ul style="list-style-type: none"> • Shared savings from MSSP replaces this category • Practices not assessed on cost performance for MIPS

MSSP advantages will be impacted by changes to final CMS rule (published Nov 2016)

*Medicare Shared Savings Program (MSSP) – Track 1 is an accountable care organization model, but does not qualify as an Advanced Alternative Payment Model (APM)



Individual physicians/NPs/PAs or a group practice consisting of not more than physicians/NPs/PAs can elect to be a virtual group under this subparagraph with at least one other such individual MIPS eligible professional or group practice.



- Unable to operationalize the virtual groups in time for the 2017 reporting period
- Governance and operation was delayed in the proposed rule
- May tackle governance in the final rule after pushback



- Eliminates small number issues in quality measures
- Pool strategic resources such as data infrastructure
- Creates an accountable community for performance
- Does not require the population health work of an alternative payment model



- Self reliance – Your score is your score alone
- A few opportunities such as the comprehensive primary care plus are available at the individual practice level

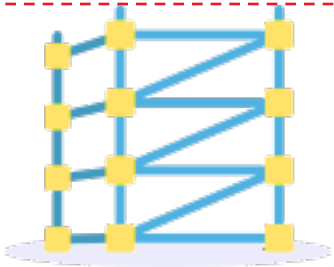
With the passage of MACRA, there is a new track for physicians in Medicare :



Track 1: Merit-Based Incentive Payment System (MIPS)

- Medicare's default payment track, starting in 2019 (performance period begins 2017)
- Practices are scored across quality, cost, EHR, and practice improvement metrics
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- Exceptional performers can receive up to 10% in bonus payments from 2019 to 2024*

Focus of this Section



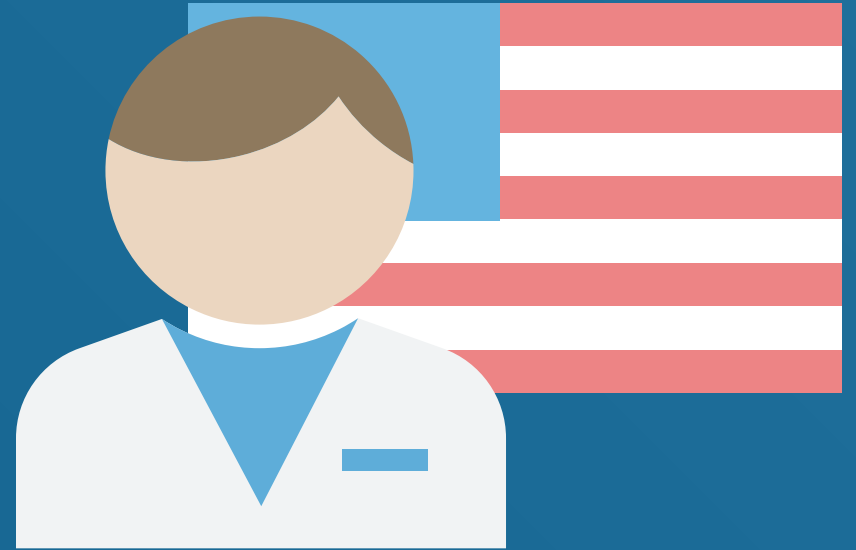
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For an entity to qualify as an alternative payment model under the MACRA statute, it must

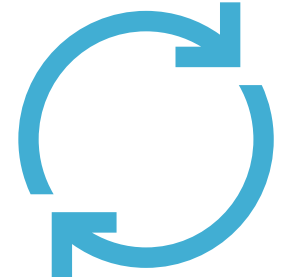
- Use Certified EHR Technology
- Report quality measures comparable to measures under MIPS
- Bear financial risk in excess of a nominal amount – or – is a Medical Home Model expanded under section of 1115A(c) of the law.



- What is Certified EHR Technology?
- What is use of Certified EHR Technology?
- What makes measures comparable to measures under MIPS?
- What is financial risk?
- How much financial risk is in excess of a nominal amount?
- What is a Medical Home Model expanded under section of 1115A(c) of the law?

What is Certified EHR Technology?

- Same thing it was yesterday so what you have in your practice today



What is use of Certified EHR Technology?

- Defined by the alternative payment model – MSSP Tracks to the current meaningful use definition – Prediction would be that it would track to the new meaningful use definition discussed in our MIPS section

Which quality measures?

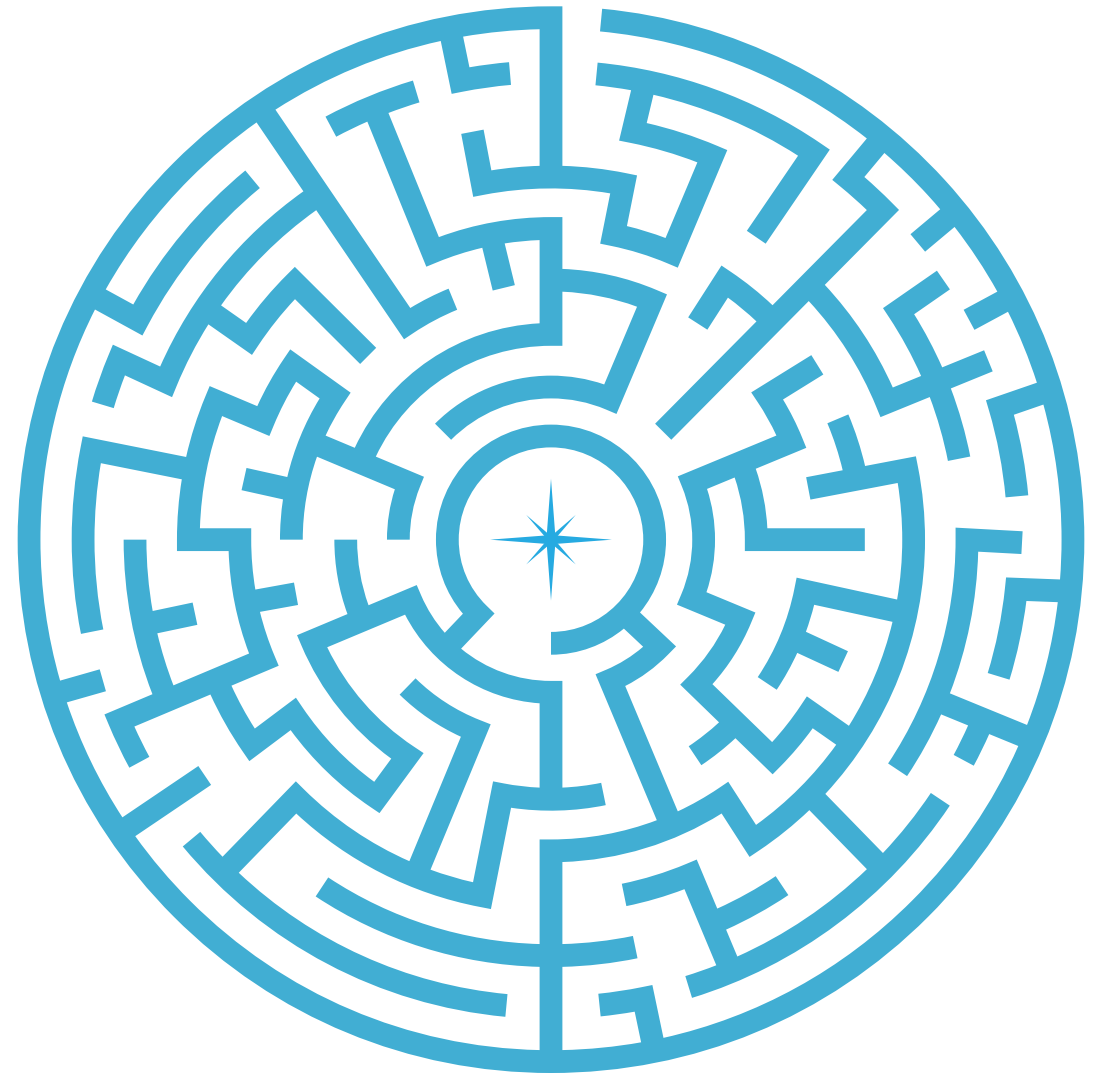
- Again defined by the alternative payment model



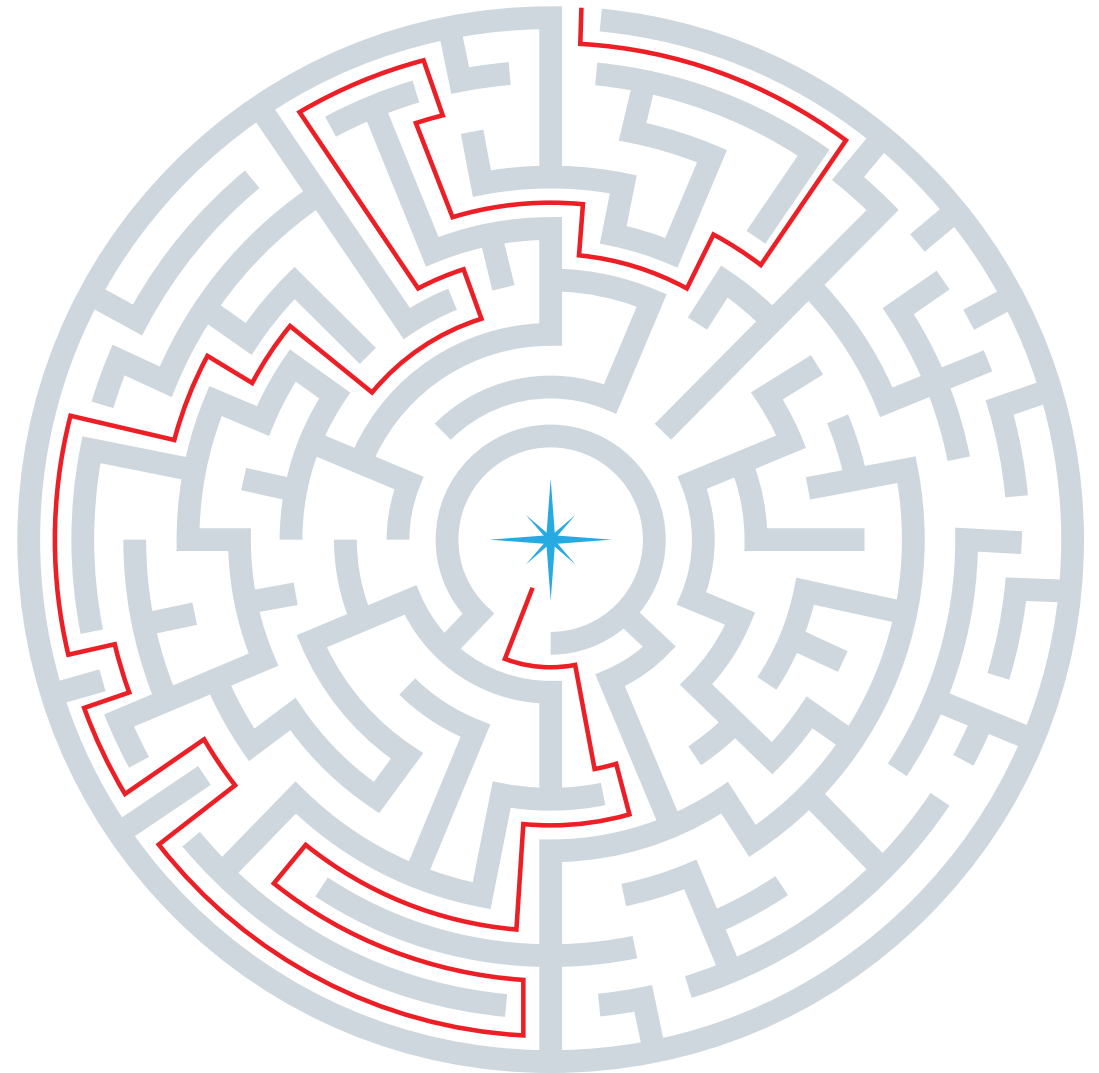
What is a Medical Home Model expanded under section of 1115A(c) of the law?

- No Medical Home Model has been expanded to date or will be in the next year

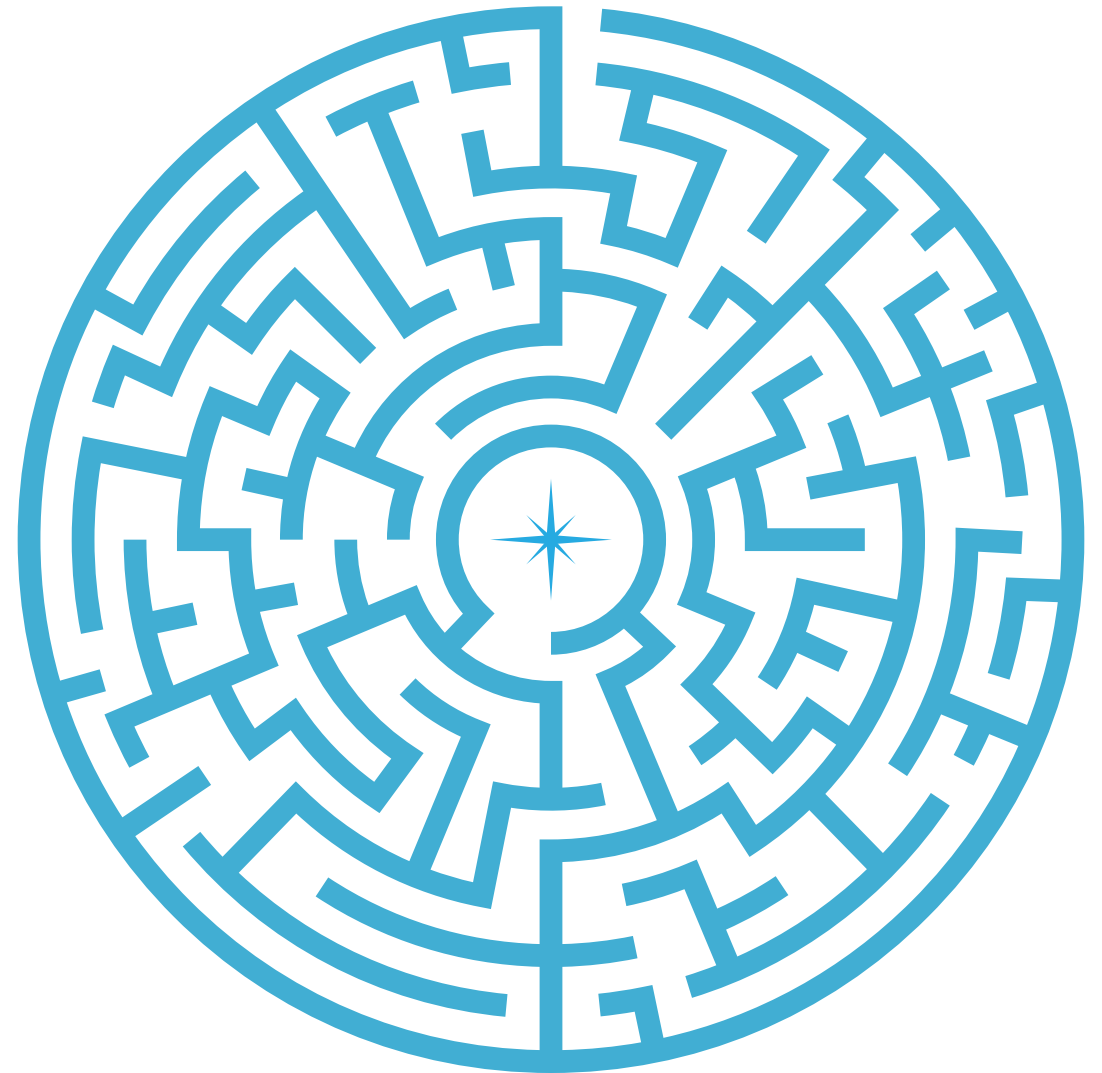
- “Withhold payment for services to the APM Entity and/or the APM Entity’s eligible clinicians”



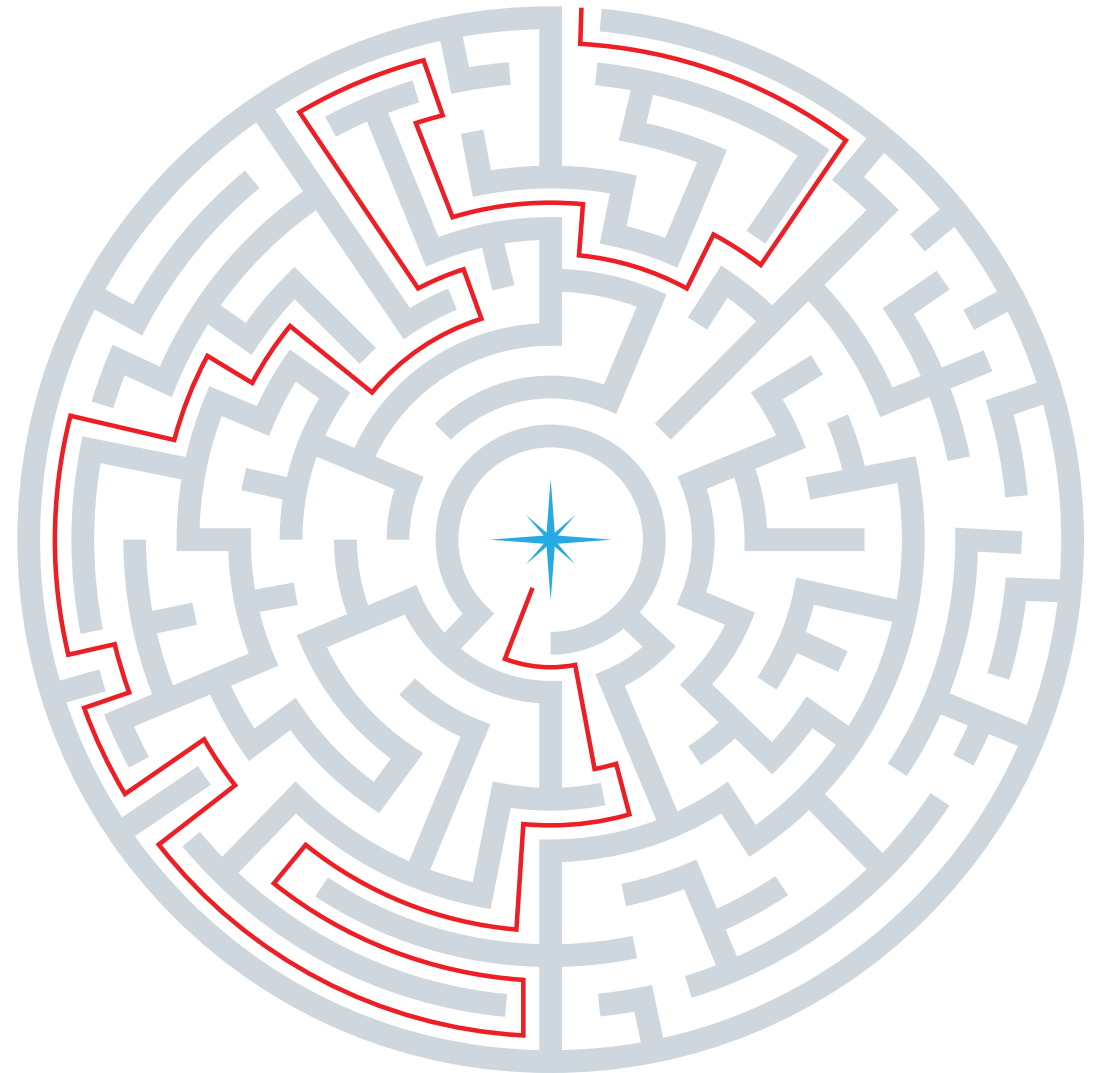
Translation: Not at all for services that would have been paid for outside the model until you meet a performance target in the model



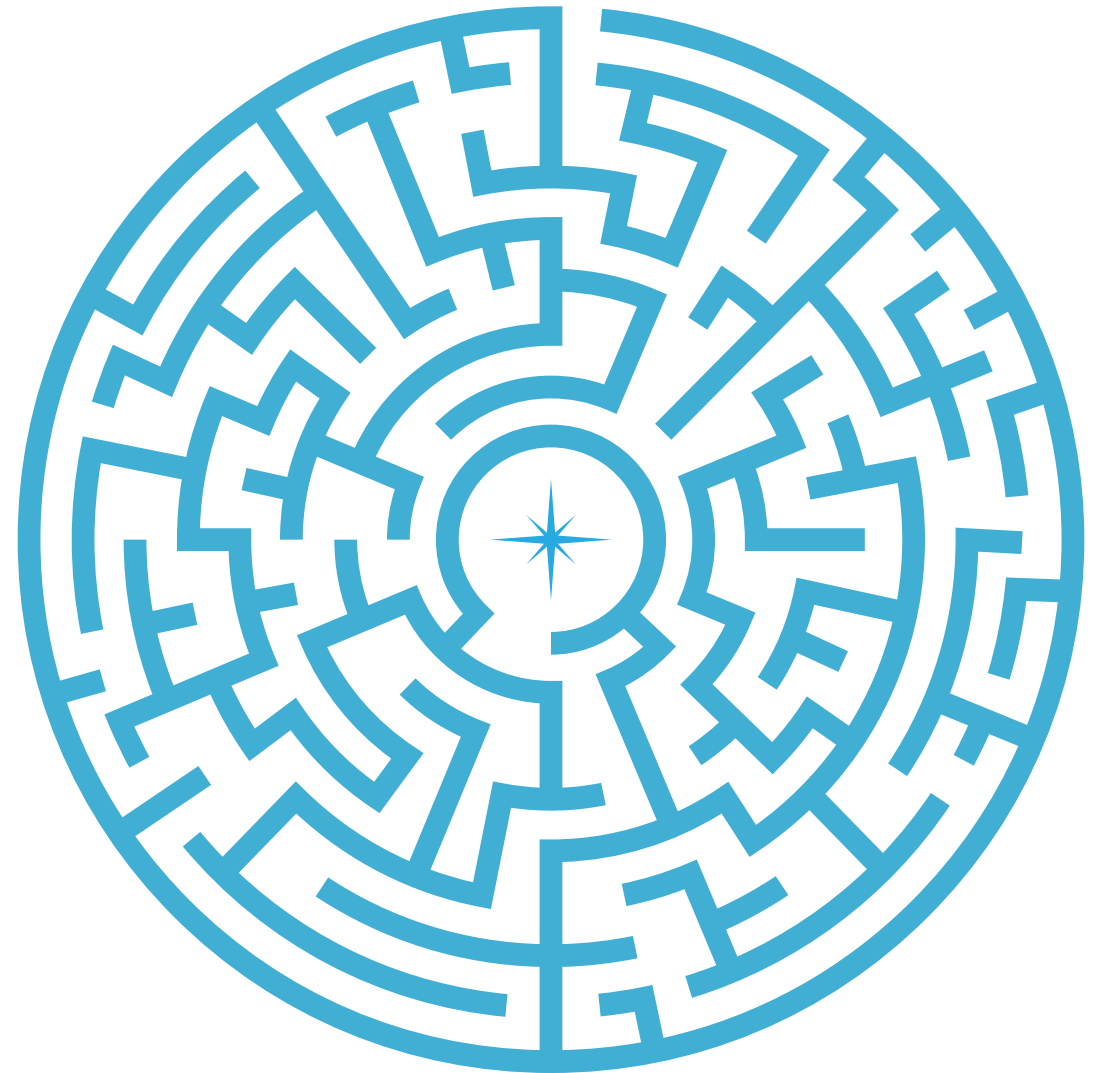
- “Reduce payment rates to the APM Entity and/or the APM Entity’s eligible clinicians; or”



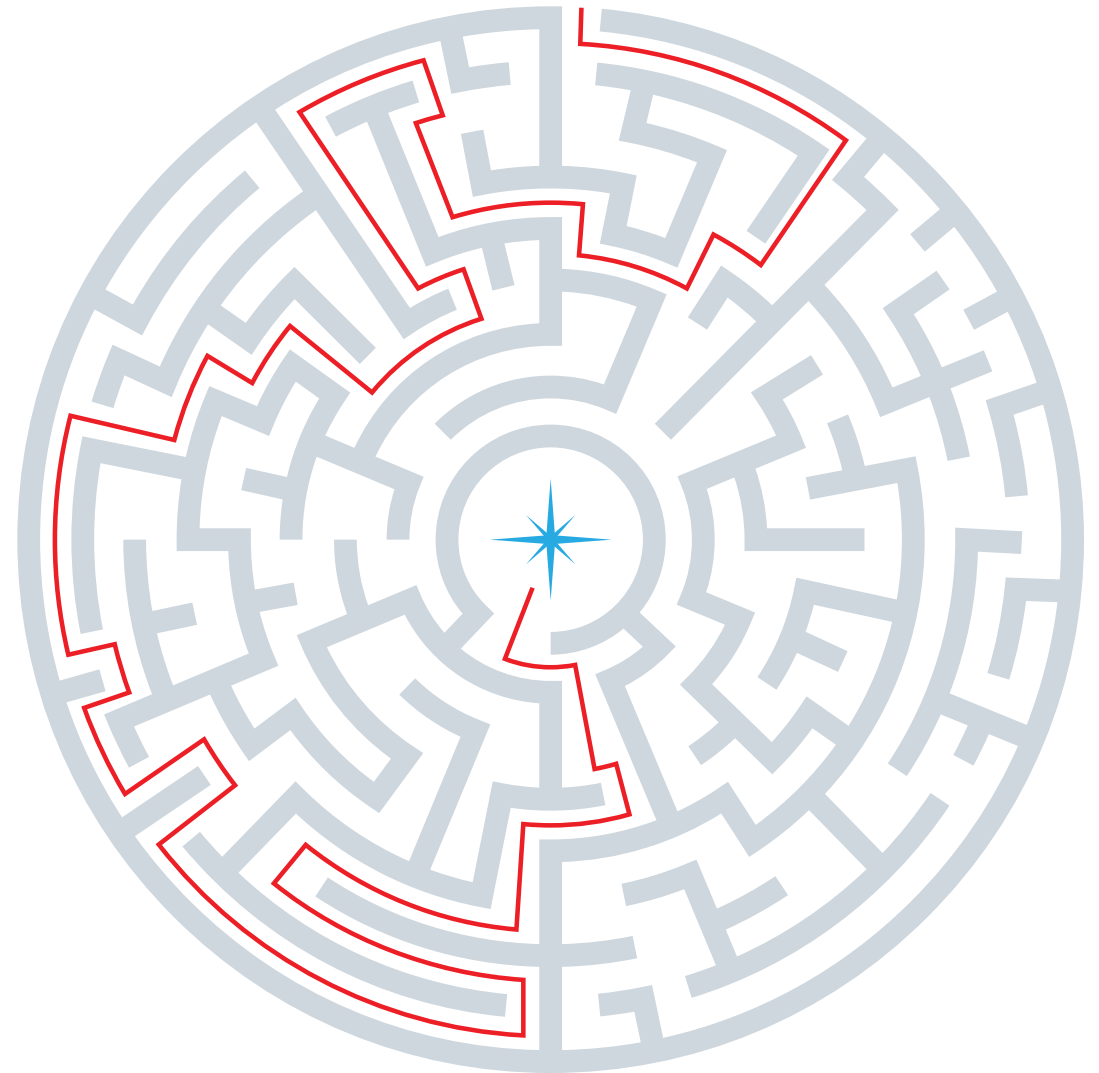
Translation: Not as much for services as would have been paid for those same services outside the model until you meet a performance target in the model



- “Require the APM Entity to owe payment(s) to CMS.”

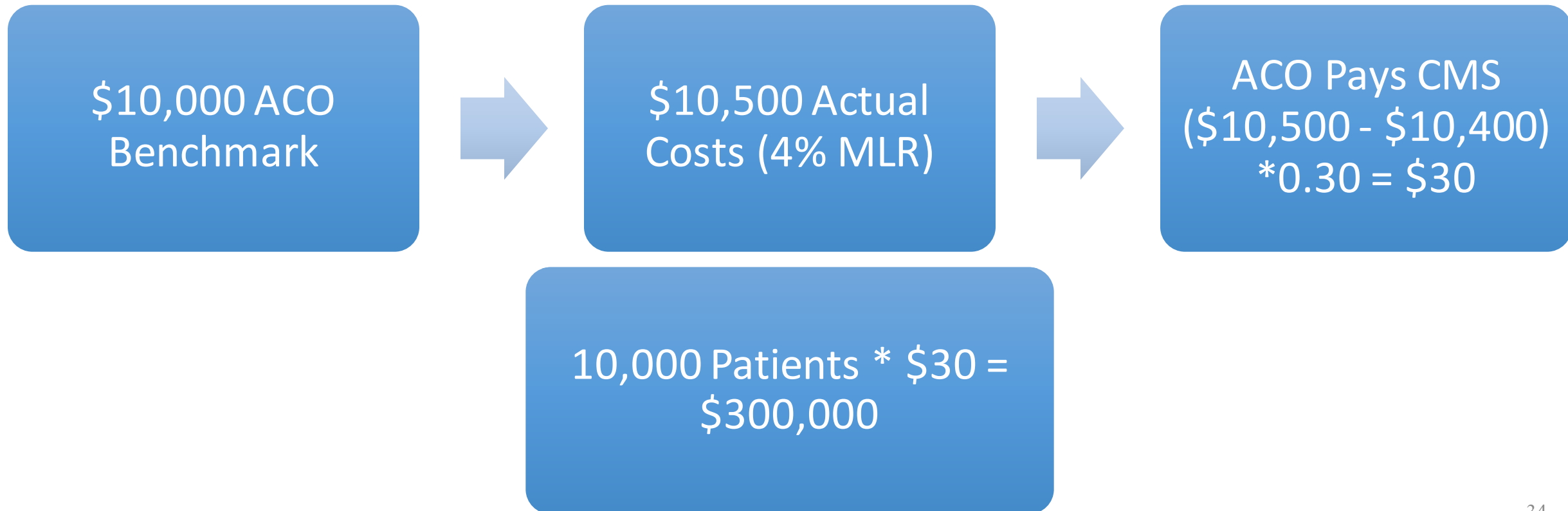


Translation: Writing CMS a check due to not meeting a performance target in the model



How much financial risk is more than nominal?

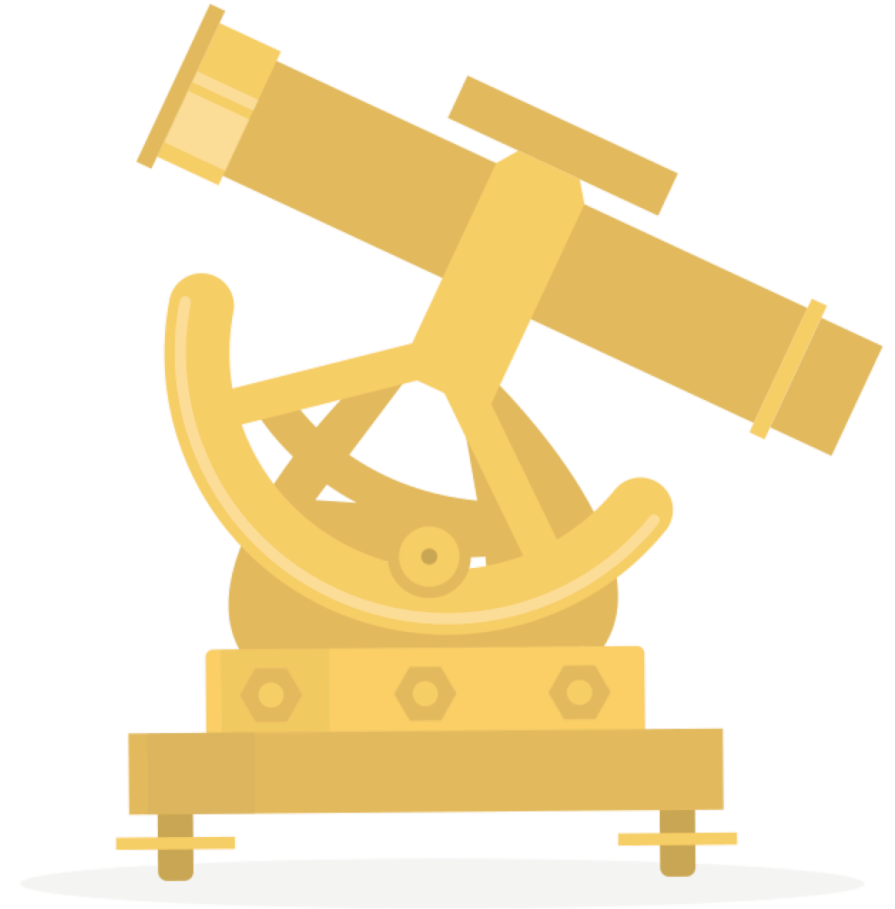
- Entity must be on the hook to pay back at least 30% of the losses that are greater than 4% of the denominator to qualify, or
- Entity must be on the hook to pay back losses totaling 4% or more of the denominator



APM	Advanced (Y/N)	Why?
Track 1 Medicare Shared Savings Program	N	No financial risk under the proposed definition
Track 2 Medicare Shared Savings Program	Y	Financial risk under the proposed definition
Track 3 Medicare Shared Savings Program	Y	Financial risk under the proposed definition
Next Generation ACO	Y	Financial risk under the proposed definition
Bundled Payment for Care Improvement Model	N	No certified EHR technology requirement
Comprehensive Care for Joint Replacement	N	No certified EHR technology requirement
Comprehensive Primary Care Plus	Y	Meets special medical home requirements
Comprehensive ESRD Care LDO Arrangement	Y	Financial risk under the proposed definition

Policy Change

- Changing the definition of financial risk to be based on 15% of Medicare revenue
- Creating a new track of MSSP with a stop loss at 15% of Medicare revenue



Under AAPM, your practice faces 2 changes to Medicare payments:

1

Fee Schedule Increases

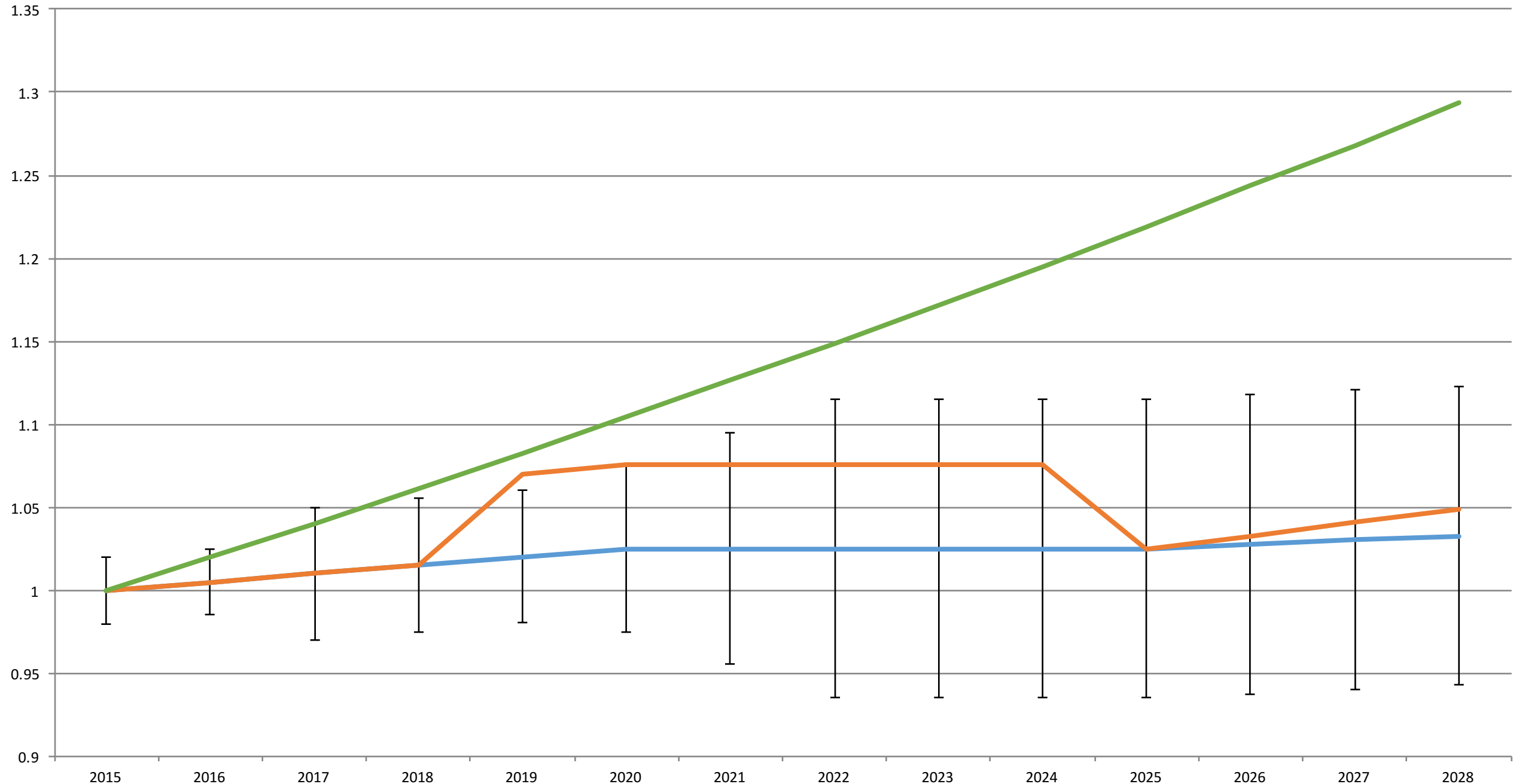
- Baseline increases of 0.5% per year to your Medicare payments from 2016 to 2019
- Baseline increases of 0.75% per year to your Medicare payments, starting in 2026*

2

AAPM

- 5% lump sum bonus on Medicare Part B payment from 2019 to 2024

FFS (Non-Advanced Payment Model) FFS (Advanced Payment Model) 2% Inflation



1

Practice Readiness

- Familiarity with Electronic Health Records and other technologies
- Openness to change
- Ability to implement new processes into the practice quickly

2

AAPM Bonus Payments

- Access to total cost of care or episodic cost of care
- ROI on investments in change and technologies
- Risk of failure in the model

3

Partnership (Key to Small Practices)

- Resources and expertise offered by the partners
- Financial alignment within the partnership
- Risk mitigation offered by the partner
- Your fellow practices on the journey with you

Appendix



Acronym	Program	Description
MU	Meaningful Use	<p>Part of the EHR Incentives & Certification program, Meaningful Use defines the ways in which healthcare providers are required to use certified electronic health records to improve quality/safety /efficiency, engage patients and family, improve care coordination and population health, and maintain privacy and security of patient health information.</p> <p>Meaningful Use guidelines are staggered into 3 stages, with requirements gradually expanding from 2011 to 2016. Failure to attest to Meaningful Use results in annual penalties of up to 3% of Medicare payments by 2017.</p> <p><i>Note: Penalties and incentives under Meaningful Use will expire in 2018</i></p> <p>For more information, see guidelines published by the Office of the National Coordinator.</p>
PQRS	Physician Quality Reporting System	<p>The Physician Quality Reporting System is a program overseen by CMS that requires physicians and group practices to report specified quality metrics. Failure to report the specified quality data face penalties of 2% of Medicare payments by 2017.</p> <p><i>Note: Penalties and incentives under PQRS will expire in 2018</i></p> <p>For more information, see the guidelines published on the CMS website.</p>

Acronym	Program	Description
SGR	Sustainable Growth Rate	<p>Established in 1997 to control Medicare payments to physicians, the sustainable growth rate (SGR) determined a target maximum growth rate in total Medicare physician payments. If the actual growth rate exceeded the target maximum, Medicare would cut all physician payments indiscriminately to meet the target growth rate.</p> <p>Since 2002, Congress passed temporary “doc fixes” each year to avoid cutting physician payments.</p> <p><i>Note: The passage of MACRA in 2015 repealed the SGR in favor of a new value-based payment system.</i></p>
VM	Value Based Payment Modifier	<p>The Value-Based Payment Modifier (VM) is a physician payment program designed to incentivize or penalize physicians according to their performance along several quality and cost metrics (quality metrics are reported under PQRS).</p> <p>The VM program was the precursor to MIPS, with physician practices facing gradual introduction of penalties and incentives up to +4x% / -4% of Medicare payments from 2016 to 2018.</p> <p><i>Note: All eligible professionals (i.e., all currently practicing physicians with Medicare patients) in the U.S. face penalties and incentives determined by the VM program through 2018.</i></p> <p>For more information, see the guidelines published on the CMS website.</p>

- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program.html>
- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf>
- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MIPS-NPRM-Slides.pdf>

Questions?