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# Getting Ready for MACRA

## A How-To Guide on Navigating Through CMS' New Payment Model

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# Introduction

Medicare payments for services rendered by physicians have been facing drastic changes throughout 2016. In 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) was passed with the intention of replacing the Medicare Sustainable Growth Rate, which in itself was both problematic and in need of a change.

This new legislation has already begun creating ripples. Taking note of the implications of such reform, healthcare organizations have begun preparing for the changes that inevitably lie ahead. With the final rule due to be released later in 2016, eligible clinicians are expected to begin preparations now in order to avoid a last-minute struggle as the year-one reporting period projected start date of January 1, 2017 approaches.

In order to prepare for such changes, understanding the basics behind this legislation is key.

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# What is MACRA?

US President Barack Obama issued the Medicare Access and CHIP Reauthorization Act in April 2015. The law enables the following:

- Nullifies the Sustainable Growth Rate (SGR) method and helps update the Medicare physician fee schedule
- Establishes flat fee or positive annual updates for ten years as well as incorporates a two-track fee update, which is set to begin in 2019
- Incorporates the Merit-Based Incentive Payment System (MIPS), which comprises the existing quality programs related to Medicare
- Creates an opportunity for clinicians and physicians to be involved in advanced Alternative Payment Models (APMs)
- Incorporates multiple quality programs, such as Physician Quality Reporting Program
- Connects the majority of the payment service fees to quality and value

The MACRA umbrella covers most clinical providers of Medicare Part B services.

It has helped create two tracks of payment: Advanced Alternative Payment Models (APMs) and the Merit-Based Incentive Payment System (MIPS). The proposed rule has narrowly defined the Advanced APMs as bearing some risk-susceptible models, such as Medicare Shared Savings Program Track 2 and Track 3.

This leaves a majority of clinicians to depend on MIPS. These changes have been named the Quality Payment Program, enabling physicians to choose between two paths of payment.

The MACRA Quality Payment Program will help clinicians, as well as patients, as they are now able to pay for value and improved care. MIPS and APMs will tentatively run from 2015 through 2021 with the hopes of pushing further given the projected success of these reforms.

## What is MIPS?

MIPS is part of MACRA's new program which combines qualities of the Value Modifier (VM or Value-based Payment Modifier), the Physician Quality Reporting System (PQRS) and the Medicare Electronic Health Record (EHR) into a singular program that measures eligible clinicians based on the following:

- **Clinical Practice & Improvement**
- **Efficient Utilization of Certified EHR Technology**
- **Resource Use**
- **Quality**

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# What are APMs?

APMs allow patients to identify new ways to pay for care provided by healthcare professionals to Medicare beneficiaries. For example, from 2019 to 2024, APMs will allow patients to pay some healthcare providers a lump sum payment.

It also helps in increasing the transparency of payment models in regards to physicians. This model will also offer some healthcare providers substantially higher annual payments.

As the federal government takes a significant leap into the value-based world, eligible physicians can expect a whole new platform regarding payment methods. With the SGR removed in 2015, MACRA now stands as the proposed final rule that will allow physicians to calculate how their payments and fees will be determined.

This rule, however, applies only to physician practices and not hospitals, as MACRA rules cover these offices. This program also applies to payments made by Medicare to physicians.

The payments and penalties involved with Medicare under MACRA will be issued starting in 2019. The US Centers for Medicare and Medicaid Services (CMS) will use data collated in 2017 to determine payment methods for the year 2019. All physicians are entitled to a 0.5% increase in reimbursement rate from 2016 through 2019. Once MACRA is in motion, physicians can choose from either the APMs or MIPS route of payment.

For the first year at least, it is expected that most physicians will choose to report through MIPS. The collected data will be utilized by CMS to identify which medical providers qualify for the APM route of payment. However, the program is flexible and physicians need not remain fixed to one route; they can switch between routes annually.

## The MIPS Route

With MIPS, physicians will be paid based on four criteria: quality, advancing care information, clinical practice improvement, and cost/resource utilization.

How well a physician scores in these categories will determine how much they will be paid.

- **Quality**

  Essentially, this is a modified version of Physician Quality Reporting System (PQRS). Physicians are allowed to select six quality criteria from a list of options specific to practices. They will use these criteria for reporting. Currently, physicians are required by PQRS to report on a total of nine quality criteria.

- **Advancing Care Information**

  Under the new MACRA program, physicians are entitled to 50% credit by simply attesting. The remainder of the score covers performances on measures that involve categories, such as care coordination, patient engagement, patients' electronic access to their health information, and electronic exchange of health information.

- **Clinical Practice Improvement Activities**

  To be eligible, physicians need to score at least 60 points in this category by becoming involved in programs that will help improve their practices in measures, such as patient engagement, patient safety, and care coordination.

- **Cost**

  This category has taken the spot of the value-based modifier. CMS will calculate scores straight from Medicare claims without direct involvement from physicians.

## The APMs Route

It is expected that a significant number of healthcare providers will be eligible for the APM mode of payment after the first year. From 2019 to 2024, clinicians who are participating in APMs are entitled to receive a lump sum payment of 5% of their previous year's Medicare Part B payment. APMs include payment models, such as Patient-Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs).

For APMs to qualify, MACRA rule states that they have to meet three criteria:

1. Physicians and medical care providers must use certified Electronic Health Record (EHR) technology.

2. APMs should pay clinicians based on quality measures that are comparable to those used in MIPS quality performance category.

3. Physicians must participate in risk-sharing, such as part of an ACO-type arrangement, or be an accredited PCMH.

## Top 3 Priorities for MACRA Success

For physicians to be eligible for payments under APMs or MIPS, they should begin focusing on three areas:

### 1. *Join and fully participate in an APM team*

Negative payment adjustments will most likely hit individual practitioners or small clinics the hardest. It is therefore not just the practice alone but a team effort involving controlling cost and improving quality.

Creating a team will help clinicians pool resources, participate in co-management arrangements, and reduce chances of risk. Solo physicians who do not score well may find it difficult to join an APM team.

### 2. *Control downstream spending with high-value referral partners*

The average physician makes an estimated 1,000 referrals each year, bringing in around ten million dollars in downstream healthcare spending. Consequently, a group of 100 physicians control one billion dollars of healthcare spending, and yet, they could have more than 16,000 patients receiving care from elsewhere by way of referrals. This makes it difficult for physicians to manage costs as they would not know where their patients are receiving care and services.

Referrals are therefore a prime opportunity for controlling both quality and cost.

For effective management, it is ideal to put patients with the highest value providers and maintain clear visibility with that patient care. Physicians can create a network or a closed-loop referral circle which allows them to ensure that referrals are made appropriately and that diagnosis and treatment are coordinated and expedited effectively.

With this network, clinicians can remain in control of the cost of care as well as downstream quality, enabling them to boost their MIPS scores as well as APM revenue.

## 3. *Become involved in Medicare's Chronic Care Management Program*

One of the biggest keys to succeeding in accountable care is managing high-risk patients. It is important that physicians provide frequent and proactive care for patients with chronic illnesses.

The CMS Chronic Care Management (CCM) program helps physicians become more involved with high-risk patients. The CCM program offers monthly non-face-to-face clinical meetings between physicians and patients who suffer from two or more chronic ailments. Through this program, CMS is downsizing resource investments as well as necessary infrastructure using MACRA.

This helps CMS fund preventive care management for those who fall within the most high-risk and costly segment of the healthcare population.

Physicians should take advantage of this program.

## Looking Ahead

The final rule will not be out until late 2016, but it is evident that MACRA is making its mark, and physicians must begin making changes conducive to the new direction.

By proactively preparing for such changes, medical providers will not only increase their likelihood of avoiding penalties, but also position themselves in a way that makes moving forward more tailored for success.

> Overall, in the world of risk-based payments, MACRA is set to prepare physicians to be more involved with their patients, while potentially bringing them more success as medical care providers.