MACRA, MIPS AND APMS: WHAT TO EXPECT AND HOW TO PREPARE

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TODAY’S DISCUSSION TOPICS

• How did we arrive at Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) Rule?
• Summary of MACRA Rule
  ▪ Merit Based Incentive Program (MIPS)
  ▪ Advanced Alternative Payment Models (APMs)
• Strategic implications of MACRA Rule
How Did We Arrive at Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) Rule?
PART B GRADUAL SHIFT TOWARD VALUE

1965 Medicare is born

1984 Medicare Economic Index (MEI) introduced

1989 Resource-Based Relative Value Scale (RBRVS) & Volume Performance Standard (VPS) introduced

1997 Sustainable Growth Rate (SGR) replaced VPS

2006 Physician Quality Reporting System (PQRS) initiated

2009 HITECH Act enacts meaningful use & incentive payments

2010 ACA requires value-based payment modifier

2006 Resource-Based Relative Value Scale (RBRVS) & Volume Performance Standard (VPS) introduced

2009 MACRA: MIPS & APMs, SGR eliminated
Hospitals have largely been focus of payment reform with providers playing role in care coordination & redesign. MACRA is the result of years of disjointed regulatory pressures on doc practices & need to align CMS payment systems toward value.

“Docs send $1.56M per/year to hospitals despite value-based push”

US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures

Senate passes SGR bill 92 to 8, avoids April 15 payment cuts

The bill ends years of “doc fixes” to stop mandatory physician pay cuts from taking effect under a SGR formula for controlling costs.
CMS SHIFT PAYMENT AWAY FROM FEE-FOR-SERVICE

- All Medicare FFS (Categories 1–4)
- FFS Linked to quality (Categories 2–4)
- Alternative payment models (Categories 3–4)

Summary of MACRA Rule
MACRA OBJECTIVES

• Permanently eliminates SGR (& its annual physician payment cuts)
• Consolidates Medicare quality reporting programs (PQRS, value-based modifier, & meaningful use rules)
• Establishes four new payment tracks
  ▪ Merit-Based Incentive Payment System (MIPS)
  ▪ Testing Quality Payment Program (new – ST)
  ▪ Partial Reporting Year Participation (new – ST)
  ▪ Advanced Alternative Payment Models (APMs)
• Consolidates financial impacts
• Ranks peers nationally & reports scores publicly
MACRA MILESTONES

• 2016
  ▪ Likely last year for PQRS, meaningful use & VBPM as programs currently operate (although effects already determined by 2016 & prior activity will continue until 2019)

• 2017
  ▪ Likely first performance measurement year for MIPS & new reporting options
  ▪ APM criteria set, proposals accepted for review

• 2018
  ▪ Likely first performance measurement for APMs
  ▪ PQRS, meaningful use & VBPM programs likely sunset December 31st
  ▪ Likely first year of broader participation in MIPS for all providers

• 2019
  ▪ First MIPS payment adjustments applied
  ▪ First APM performance assessed
### MIPS Reporting (Fee-For-Service)

- **Statutory updates**
  - 0.5% 2015–2019 JUL
  - 0% starting 2020
- **Consolidated reporting into MIPS**
- **Reduced penalty risk in 2019 for MIPS**
  - No adjustment for test reporting
  - Minimal upward adjustment for partial year reporting
- **Most providers will fall under MIPS** – everyone reports in 2017

### Alternative Payment Models (Fee-For-Service + Risk-based)

- **Bonus of 5% in 2019–2024** to aid transition to new models
- **Exempt from MIPS**
- **Requires “nominal” downside risk & increasing levels of total activity**
- **Estimated only 4%–5% of eligible clinicians will qualify for APM status in year one**
- **Certified Electronic Health Record (EHR) and quality measures**

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**Quality Payment Program (QPP)**

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**PRACTICE CHOICES UNDER MACRA**
MACRA TRACK ASSIGNMENT

Year 1
Payments:
- 25% APM
- 75% FFS

Patients:
- 20% APM
- 80% FFS

Source: CMS MACRA LAN PowerPoint, May 2016
QUALIFYING APMS

• Medicare Shared Savings Program Tracks 2 & 3
• Next Generation ACO Model
• Comprehensive ESRD Care (CEC) (large dialysis organization arrangement)
• Comprehensive Primary Care Plus (CPC+)
• Oncology Care Model (OCM) (two-sided risk track available in 2018)
• Comprehensive Care for Joint Replacement (CJR) Model – starting 2018?
• Cardiac Care Model – starting in 2018?
• Cardiac Rehabilitation Model – starting in 2018?
• Ineligible – BPCI & MSSP Track 1
MIPS SCORING

• Single MIPS Composite Performance Score (100 points) across four categories
• CMS establishes performance threshold which determines upward or downward adjustment
• Budget neutral with potential scaling factor
• Systems data collection & extraction essential across all focus areas
• Identify internal best practices & expertise to leverage across organization

**CATEGORY WEIGHTING**

<table>
<thead>
<tr>
<th>Year</th>
<th>Clinical Practice Improvement Activities (CPIA)</th>
<th>Advancing Care Information (ACI)</th>
<th>Resource Use</th>
<th>Quality</th>
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<tbody>
<tr>
<td>2017</td>
<td>15%</td>
<td>25%</td>
<td>10%</td>
<td>50%</td>
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<tr>
<td>2019</td>
<td>15%</td>
<td>25%</td>
<td>30%</td>
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MACRA TIMING & REIMBURSEMENT IMPLICATIONS

Max MPFS Base Rate Adj

<table>
<thead>
<tr>
<th>Year</th>
<th>PQRS</th>
<th>MU</th>
<th>VBPM</th>
<th>MIPS</th>
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<tbody>
<tr>
<td>2015</td>
<td>-1.5%</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>4.0%</td>
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<tr>
<td>2016</td>
<td>-1.0%</td>
<td>-2.0%</td>
<td>-3.0%</td>
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<td>2017</td>
<td>-2.0%</td>
<td>-4.0%</td>
<td>-4.0%</td>
<td>7.0%</td>
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<td>2018</td>
<td>-2.0%</td>
<td>-4.0%</td>
<td>-4.0%</td>
<td>9.0%</td>
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<tr>
<td>2019</td>
<td>-2.0%</td>
<td>-4.0%</td>
<td>-4.0%</td>
<td>9.0%</td>
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<tr>
<td>2020</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
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<tr>
<td>2021</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
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<tr>
<td>2022+</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
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</table>

*New reporting options currently not defined. Test reporting in 2017 will result in no payment adjustment. Partial year reporting may result in a small upward adjustment.

APM 5% annual bonus

2015: 0.5% Update
2016: 0.0% Update
2017: 0.0% Update
2018: 0.0% Update
2019: 0.0% Update
2020: 0.0% Update
2021: 0.0% Update
2022+: 0.0% Update
2026+: APM: 0.75% MIPS: 0.25%

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# MIPS Reporting

<table>
<thead>
<tr>
<th>Submission Methods</th>
<th>Quality</th>
<th>Cost</th>
<th>Clinical Practice Improvement Activities</th>
<th>Advancing Care Information</th>
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<tr>
<td>Qualified Clinical Data Registry</td>
<td>X</td>
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<tr>
<td>Qualified Registry</td>
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<td>Electronic Health Record</td>
<td>X</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Administrative Claims (No Submission Required)</td>
<td>X</td>
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<tr>
<td>CMS Web Interface (Groups of 25 or More)</td>
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<td>CAHPS for MIPS Survey</td>
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<tr>
<td>Attestation</td>
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MIPS OVERVIEW – QUALITY

• Replaces PQRS & quality component of value modifier program
• Choose to report six measures (nine under PQRS)
  ▪ More than 200 measures to pick from
  ▪ 80% of measures tailored for specialists
  ▪ Crosscutting measure, outcome measure (if available, or another high quality measure)
  ▪ CMS calculates three population-based measures
• May also report specialty measure set instead of six measures
### MIPS QUALITY MEASURE INVENTORY

- Outline quality measures reported internally & externally
  - What are we measuring?
  - Data completeness requirements
  - External reporting requirements
  - Internal quality initiatives
- Obtain available quality reporting data (PQRS, registries)
- Identify possible MIPS measures by specialties in comparison to inventory

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure Description</th>
<th>Data Completeness</th>
<th>Internal Reporting</th>
<th>External Reporting</th>
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<tbody>
<tr>
<td>1</td>
<td>Example 1</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>2</td>
<td>Example 2</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>3</td>
<td>Example 3</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>4</td>
<td>Example 4</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>5</td>
<td>Example 5</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
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</tbody>
</table>

**Legend:**
- **Yes:** Available
- **No:** Not Available
MIPS OVERVIEW – COST

• Replaces cost component of value modifier program
• Score based on Medicare claims (no reporting)
  ▪ Total per capita cost, Medicare spending per beneficiary
• Over 40 episode-specific measures to account for differences among specialties
### CARE COST INVENTORY

- Obtain & assess available Medicare Quality & Resource Use Reports (QRUR)
  - What are our results by practice or specialty?
  - What are our outlier diagnosis-related costs?
  - What are our outlier sites of service?
- Obtain & assess any other available care cost data in general use to help identify high cost diseases & opportunities for improvement

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**Table 6. Per Episode Costs, by Categories of Service, for the Medicare Spending per Beneficiary Measure**

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Number of Your TIN's Episodes with Costs in This Category</th>
<th>Percentage of Your TIN's Episodes with Costs in This Category</th>
<th>Your TIN's Per Episode Costs</th>
<th>Benchmark Percentage of Episodes with Costs in This Category</th>
<th>Benchmark Per Episode Costs</th>
<th>Amount by Which Your TIN's Episode Costs Were Higher or Lower Compared to the Benchmark</th>
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<tbody>
<tr>
<td>ALL SERVICES</td>
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<tr>
<td>Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)</td>
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<td>Evaluation &amp; Management Services</td>
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<tr>
<td>Major Procedures and Anesthesia</td>
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<tr>
<td>Ambulatory/Inpatient Procedures</td>
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<tr>
<td>Outpatient/Physical, Occupational, or Speech and Language Pathology Therapy</td>
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<td>Ancillary Services</td>
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<td>Laboratory, Pathology, and Other Tests</td>
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<tr>
<td>Imaging Services</td>
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<tr>
<td>Durable Medical Equipment and Supplies</td>
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<tr>
<td>Hospital Inpatient Services</td>
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<tr>
<td>Inpatient Hospital Trigger</td>
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<tr>
<td>Inpatient Hospital Readmission</td>
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<tr>
<td>Emergency Services Not Included in a Hospital Admission</td>
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<tr>
<td>Emergency Evaluation &amp; Management Services</td>
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<td>Procedures</td>
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<td>Laboratory, Pathology, and Other Tests</td>
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<tr>
<td>Imaging Services</td>
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<td>Post-Acute Services</td>
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<td>Home Health</td>
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<tr>
<td>Skilled Nursing Facility</td>
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<td>Inpatient Rehabilitation or Long-Term Care Hospital</td>
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<tr>
<td>Hospice</td>
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<tr>
<td>All Other Services</td>
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<tr>
<td>Ambulance Services</td>
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<td>Chemotherapy and Other Part B-Covered Drugs</td>
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<tr>
<td>Dialysis</td>
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<tr>
<td>All Other Services Not Otherwise Classified</td>
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</table>
MIPS OVERVIEW – ADVANCING CARE INFORMATION

• Replaces meaningful use
  ▪ Moves away from “all or nothing” to benchmark scoring system
  ▪ Particular emphasis on interoperability & information exchange

• Base score (50 points)
  • Protect patient health (yes/no)
  • Patient electronic access (numerator/denominator)
  • Coordination of care (numerator/denominator)
  • Electronic prescribing (numerator/denominator)
  • Public health & clinical data registry reporting (yes/no)

• Performance score (80 points)
  ▪ Patient electronic access
  ▪ Coordination of care through patient engagement
  ▪ Health information exchange

• Public health registry (bonus point)
  • Immunization registry reporting required

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MIPS OVERVIEW – CLINICAL PRACTICE IMPROVEMENT ACTIVITIES

• Ninety Options for improvement activities examples:
  ▪ Care coordination
  ▪ Beneficiary engagement
  ▪ Patient safety & practice assessment
  ▪ Expanded practice access
  ▪ Achieving health equity
  ▪ Population management
  ▪ Emergency preparedness & response
Strategic Implications of MACRA Rule
STRATEGIC IMPLICATIONS

• MACRA five-year reimbursement risk on stand-alone basis likely less than cost of infrastructure required to fully maximize reimbursement effect

• Efforts to maximize MACRA reimbursement effect could likely have opposite (& potentially more material) downstream reimbursement effects for various providers in FFS environment

• MIPS cost per attributed beneficiary & outcomes parameters create most significant infrastructure needs
  ▪ Similar to bundled payment initiatives needs (e.g., CJR), but much more encompassing
  ▪ Similar to ACO initiative needs regarding identification & management of attributed beneficiaries

• MACRA creates additional incentive for employed or independent physicians to actively partner with providers
• Advanced APM eligibility is difficult so providers should assume MIPS track
• Organizations need the necessary infrastructure & expertise to manage data reporting, care coordination & clinical outcomes before taking on payment risk
• No cover for eligible clinicians (with exception of those exempt); unlikely to see swaths of providers opting out of Medicare participation
• Will likely see more clinicians & group practices move toward ACOs over time. It is crucial to understand your local market & develop potential alignment strategies with independents
STRATEGIC RECOMMENDATIONS

• Full management of MACRA requires development of “Integrated Delivery System” (IDS) infrastructure
  ▪ ROI for development of IDS infrastructure tied to extent of future value-based reimbursement penetration, MACRA not enough
• CMS value-based initiatives continue to focus on key elements
  ▪ Financial risk or reward to providers based on cost of beneficiaries to MC (hospital in CJR; physician in MACRA, etc.)
  ▪ Associated or direct financial risk or reward to providers for care outcomes
  ▪ Associated requirements for providers to coordinate care & manage care episodes
  ▪ Requirements to share medical data across providers
• Elements of MACRA can be maximized through shorter-term attention to specific MIPS parameter elements

  • Recommended approach
    ▪ Short-term: MACRA FFS Maximization
    ▪ Long-term: Integration Infrastructure Development
SHORT-TERM VISION: GOALS OF MACRA FFS MAXIMIZATION

- Improve professional reimbursement from Medicare generated by providers in CY 2019 & later as determined under MACRA regulations utilizing CY 2017 & later parameters.
- Coordinate improvement efforts with longer-term IDS Development Plan to foster both goals, including further integration of key physicians.
LONG-TERM VISION:
GOALS OF INTEGRATED DELIVERY SYSTEM INFRASTRUCTURE

• Ability to effectively manage cost & outcomes of care for variety of defined populations across multiple provider types (attributed beneficiaries, bundled payment episodes, diagnoses populations, service line populations, etc.)
• Ability to maintain profitability through delivery of positive ROI on IDS investments
• Development of flexibility; ability to react quickly to changing reimbursement environments through effective partnering across provider types
• Development of market leadership through excellence in delivery on triple aim goals by effective partnering with best providers in care spectrum
LONG-TERM VISION:
DEVELOPMENT OF COST EFFECTIVE INTEGRATED DELIVERY SYSTEM

• “IDS” means different things to different people
• Potential elements of IDS infrastructure
  ▪ Governance & oversight
    • Structural makeup (entities, etc.)
    • Leadership & operational committee/management structures
    • Provider recruitment & alignment structures
  ▪ Information technology – data management
    • Hardware, software, integration conduits
    • Database management
  ▪ Profitability accounting structures
    • Cost/service line/diagnosis profitability accounting
    • Actuarial population health profitability accounting
  ▪ Care protocol & clinical process improvement structures
    • Development processes
    • Operational implementation processes
  ▪ Managed care structures
THANK YOU!

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