WHITE PAPER

Making Sense of MACRA

A guide to understanding the shift to value-based care
and the data infrastructure needed to support provider success.

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A COMPLEX PROBLEM WITH A COMPLEX SOLUTION

THE CAUSE: Health care costs have been spiraling out of control for decades. Since 1960, U.S. health care spending has increased from 5% of GDP to 17.8 % in 2015. In dollars, that's an annual difference of $9,984 per person. Compounding the issue, quality of care and general population health have not kept pace with rising expenditures. Much like the causes, responses and potential solutions to the problem have varied.

THE EFFECT: The latest attempt to address the trio of issues at the heart of the healthcare challenge arrived in 2015. The Medicare Access and CHIP Reauthorization Act (MACRA) was a bi-partisan effort signed into law by President Barack Obama. MACRA changes the game significantly for healthcare providers by shifting from a fee-for-service reimbursement model to a value-based system—incentivizing quality of care, rather than quantity.

MACRA, in all its 800+ page glory, went into effect on January 1st of this year and will begin impacting the real-world revenue of providers in 2019. Reimbursement at that time will consider a variety of factors, including patient outcomes and cost control measures, and is based on 2017 performance.

THE BOTTOM LINE: With the clock already ticking, providers need to act now to develop a solid understanding of the requirements and full implications of MACRA, assess their current data and measurement capabilities and build a comprehensive strategy for managing Medicare billing costs proactively.

Source: "National Health Expenditures Summary Including Share of GDP, CY 1960-2015," Centers for Medicare and Medicaid Services. "Inflation Rate by Year," The Balance.

UNDERSTANDING MACRA: MIPS vs APMs

The first thing you need to know about MACRA is that there are two basic options for participation: The Merit-based Incentive Payment System (MIPS) and the Alternative Payment Models (APM). Most practitioners will be subject to MIPS, so we'll start there.

Merit-Based Incentive Payment System

Clinicians who will be included in MIPS are physicians, physician's assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists (the list of eligible professional will likely expand in 2021). The three forms of MIPS exemptions for clinicians who would otherwise meet the eligibility requirements are the following:

- Clinicians in their first year of Medicare Part B participation
- Clinicians in entities sufficiently participating in an Advanced APM (more on this later)
- Clinicians billing Medicare Part B up to $90,000 in allowed charges OR providing care for up to 200 Part B patients in one year

Note: Originally the threshold for billing was $30,000 and number of patients was 100 but CMS adjusted this measurement in an attempt to reduce the reporting stress on small practices.

The MIPS Composite Performance Score (CPS)

MIPS reimbursement is based on a composite performance score (CPS). It's important to take the time to understand the basics on how this is calculated, especially because MIPS allows for a certain level of flexibility for clinicians to choose measurements that are most meaningful to their practice.

In short, MIPS combines and streamlines three existing federal reporting programs:

- Physician Quality Reporting System (PQRS)
- Value-based Payment Modifier (VBM)
- Medicare Electronic Health Record (EHR)

It will also include a fourth category in the calculation called "Clinical Practice Improvement Activities (CPIA)." These "four statutory pillars" are what make up the CPS metric and determine whether an eligible professional will receive a payment bonus, a penalty or no adjustment at all.

Source: Centers for Medicare & Medicaid Services

The Quality Score

The quality category is largely based on PQRS though the number of measures to report will drop from 9 to 6. One measure chosen by the clinician must be outcome based (or high-value) and one must be a cost-cutting measure. The Quality category will have a 60% weighting for the first and second performance year so it is worth the effort to become familiar with the measures you can choose from to make sure you are reporting on the highest potential performance measures.

The Resource Use Score

The Resource Use category replaces the Value-based Modifier (VM) and was originally proposed to have a weight of 10% in a participant's CPS metric. This category was then simplified and weighted to zero for performance year 2017 and 2018 to allow clinicians to improve their understanding of the measures and ease into the Quality Payment Program.

It's important to note that CMS states that their intent is to adjust the weights to "align cost measures with quality measures over time in the scoring system." Which means that we may see that both quality and cost each account for 30% of the CPS in 2019.

The Clinical Practice Improvement Activities Score

Clinical Practice Improvement Activities (CPIA) is a new category and will have a weighting of 15% of the overall CPS. CMS stated in its June 30th proposed rule that "improvement activities are those that support broad aims within healthcare delivery, including care coordination, beneficiary engagement, population management, and health equity." This category requires a selection of one CPIA activity (from 90+ proposed activities) with additional credit for more activities.

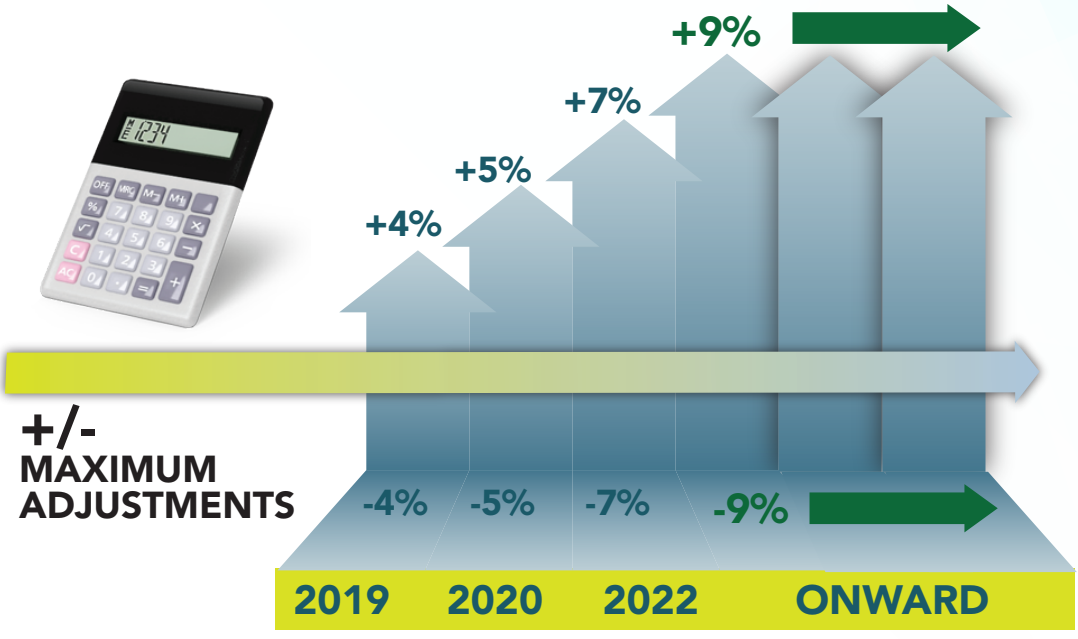
Advancing Care Information Score

The Advancing Care Information is similar to Meaningful Use (MU) and has a weighting of 25% of the CPS. It is focused on interoperability and information exchange and measures how well you are making "meaningful use" of your Electronic Health Records (EHR). One metric in this category will be measured by the use of a Certified EHR technology (CEHRT) "to support patient engagement and improved healthcare quality" and CMS recommends that physicians and clinicians "migrate to the implementation and use of EHR technology certified to the 2015 Edition" but they have recognized the challenges some may have in adopting new certified IT and proposed that clinicians may continue to use 2014 edition CEHRT for the 2018 performance year. That said, as an incentive to still make the change next year, providers who do use the 2015 Edition would receive a 10 percent ACI bonus.

Payment Adjustment Range

MIPS reimbursement is dependent on how your overall Composite Performance Score (CPS) stacks up against the MIPS performance threshold.

The adjusted payments will start at plus or minus 4 percent in 2019 and incrementally increase to 5 percent, 7 percent and then 9 percent in 2020, 2021 and 2022, respectively.



Source: Centers for Medicare & Medicaid Services

There will also be a 3 times multiplier bonus available for those who achieve the 25th percentile. Therefore, by 2022 your MIPS score could earn you a 27% adjustment increase, or conversely you could lose up to 9% of your reimbursement for performing poorly.

ALTERNATIVE PAYMENT MODELS

The other option under MACRA is the Alternative Payment Models (APM) which include Accountable Care Organizations (ACOs), Medicare Shared Savings Programs and Patient-Centered Medical Home models (PCMH). A clinician may join an existing APM entity or apply to CMS to create a new APM entity. In order to create a new APM entity, one must adhere to the application procedures and deadlines published by CMS.

Because APMs provide a wide array of participation options, it is important to review the variety of APMs that are available. Before a new APM is published by CMS, they decide whether the model satisfies the requirements for a 'MIPS APM,' a 'Medical Home Model,' a 'Use of CEHRT Criterion,' a 'Quality Measures Criterion,' a 'Financial Risk Criterion,' or an 'Advanced APM.'

For a list of approved Advanced APMs for the 2017 performance year visit https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf

CHARTING YOUR COURSE

As you consider which reimbursement path is best for your practice, it's important to remember that there is no one-size-fits-all approach. In keeping with the size of its impact, MACRA is a complex program with multiple additional options underneath each basic course of action. Understanding the benefits and risks of each as they apply to your unique practice is a crucial part of your success, as is an honest assessment of your current capability to comply.

MIPS

PROS

- Potential 4%+ positive payment adjustment in 2019
- Even higher adjustments for exceptional performance
- Moderate payment adjustment just for partial participation (90-day period)
- Minimal 2017 participation avoids full negative payment adjustment

CONS

- Requires additional resources to capture analyze necessary data and establish workflows
- Learning curve for team
- Up to 4% Negative payment adjustment
- Potential publication of low CMS score

APM

PROS

- Potential 5% incentive payment
- Avoidance of publicly available MIPS CPS score
- Potential to earn more if cost savings are achieved

CONS

- Exposure to financial risks
- Potential revenue loss through the shared-risk programs

ASSESSING THE LANDSCAPE

For most providers, the biggest challenge associated with MACRA implementation is the basic data strategy and infrastructure necessary for compliance. Fortunately, the issue is made a bit more manageable by the fact that you don't have to decide between MIPS and APM to start laying groundwork that will have a far-reaching benefit for your practice beyond just MACRA compliance.

Ultimately, providers will need their patients' medical cost information at their fingertips in all practice situations so they can make effective decisions to improve outcomes and lower costs overall. Starting this journey now will give you time to build trust in your data and establish the partnerships required to create an effective health neighborhood, underpinned by a new data discipline to succeed under whatever MACRA path you ultimately choose.

The following table serves as a guide to help you understand the foundational components of a modern data infrastructure for healthcare IT and how to assess the readiness of your current solution in response to the impending regulatory changes and evolving patient expectations.

PROBLEM	SOLUTION ASSESMENT	PAYOFF
1 PATIENT IDENTIFICATION: Patient data is available from a varietyof sources originating in disconnectedsystems that use different patient identifiers. Providers need to identify patient datasources and link medical history.	**Accurately identify patients** across all practice locations (internal and referred) and types of services incurred ranging from prescriptions to therapies to hospital admissions. 1. Do you have an inventory of shared data sources and have you documented patient identifier usage to determine how patient data can be linked and combined ? 2. Do data sharing policies/agreements exist between provider and other organizations harboring patient data? 3. Does current electronic health record have patient registry capability? 4. Do resources exist on staff with data analysis/stewardship skills to monitor and address patient identification issues? 5. Do you have the tools in place to load patient data , check for data quality issues, and update/fix the issues if found?	**BUILDING BLOCK TO COMBINE CLAIMS AND OTHER DATA SOURCES FOR A FULL PICTURE OF THE PATIENT EXPERIENCE.**

PROBLEM	SOLUTION ASSESMENT	PAYOFF
2 EPISODES OF CARE: Enabled by Patient Identification, yet still problematic to combine, claims and/or clinical data arrive at different times and in varying formats for any one patient. Providers need the ability to load large and varying data sets and have the flexibility to on-board new sources quickly and easily.	**Coalesce episodes of care** across locations and types of services into a unified view of care for that patient. 1. Do data sharing policies/agreements exist between provider and other organizations providing services to your patients? 2. Does technology exist to load large volumes of claims/visit data? 3. Does technology exist to connect to APIs to load data from partner EHRs? 4. Are existing tools able to load non-clinical data and/or non-traditional formats? 5. Do you have agreements in place to connect to and leverage data from Qualified Clinical Data Registries?	**INCREASED VISIBILITY INTO THE CONTINUUM OF CARE FOR YOUR PATIENTS.**
3 SUPPLY CHAIN DATA: Supply chain data typically resides in a different system and can be problematic to associate with patient outcome and cost. Providers need scalable and cost-effective ingestion and aggregation of supply chain data into their analytics solution.	**Increase provider visibility into their medical device supply chain costs.** 1. Is supply chain data available and accessible electronically? 2. Does linkage exist between medical supply chain and claims or EHR? 3. Are supply chain costs available to providers prescribing to patients in a patient setting?	**PROVIDERS CAN MAKE INFORMED DECISIONS BASED ON THE WHOLE COST OF PATIENT CARE.**
4 HEALTH NEIGHBORHOOD: Claims and clinical data only say so much. Community based services data can fill a key gap, but is not always readily available. Providers need to establish data sharing policies and practices integrating community based services data into their system.	Partner with entities providing care to your patient to **establish a virtual health neighborhood** and progress towards a patient-centered medical home. 1. Do you have agreements or partnerships in place with community based services? 2. Do you have geocoded location data for your patients? 3. Do you have lists of community based services in your practice area including geocoded location information for these services?	**IMPROVED OUTCOMES AND LOWERED COSTS.**

There are a few considerations relative to MACRA compliance in particular. If you're considering participation in MIPS, here are a few additional things to include in your assessment:

PROBLEM	SOLUTION ASSESMENT	PAYOFF
5 MIPS BENCHMARKS: MIPS benchmark baseline information is available online, but is not integrated in your data. MIPS benchmark information needs to be loaded into your system so it can be compared with your practice data enabling comparison and trending analyses.	**Aggregate MIPS benchmark data** and use in real-time analysis with current Medicare costs. 1. Do you know if you are MIPS eligible? 2. Have you picked your pace for MIPS participation: Minimal, Partial, Full? 3. Have you chosen your MIPS measures? 4. Have you reviewed your historical Medicare quality program results to predict MIPS performance? 5. Do you have an existing BI reporting system separate from your EHR? 6. Does practice have interoperability initiatives/staff/programs ongoing?	**BASELINE ESTABLISHED FOR COMPARISON OF PROVIDER PERFORMANCE AGAINST PEERS.**

The "2016 Health Catalyst/Peer 60" survey of 187 healthcare professionals revealed that 40% of respondents ranked "compiling metrics for regulatory reporting" as their biggest challenge and 33% reported that they would participate in MACRA, but currently have no strategy.

BUILDING YOUR IT INFRASTRUCTURE

The assessment guide above approached the MACRA readiness challenge from an outcome and business perspective. From a Health IT perspective, you will want to establish the following capabilities as prerequisites to achieving readiness for MACRA.

1. **Establish a modern data architecture**

   Leverage big data technologies to enable a near real-time view of your patients' interaction with their health neighborhood and a timely view of their medical history.

2. **Assess and fix data quality issues**

   Prioritize patient identifiers and demographic information generated by your practice and exchanged with other entities.

3. **Integrate new data sources**

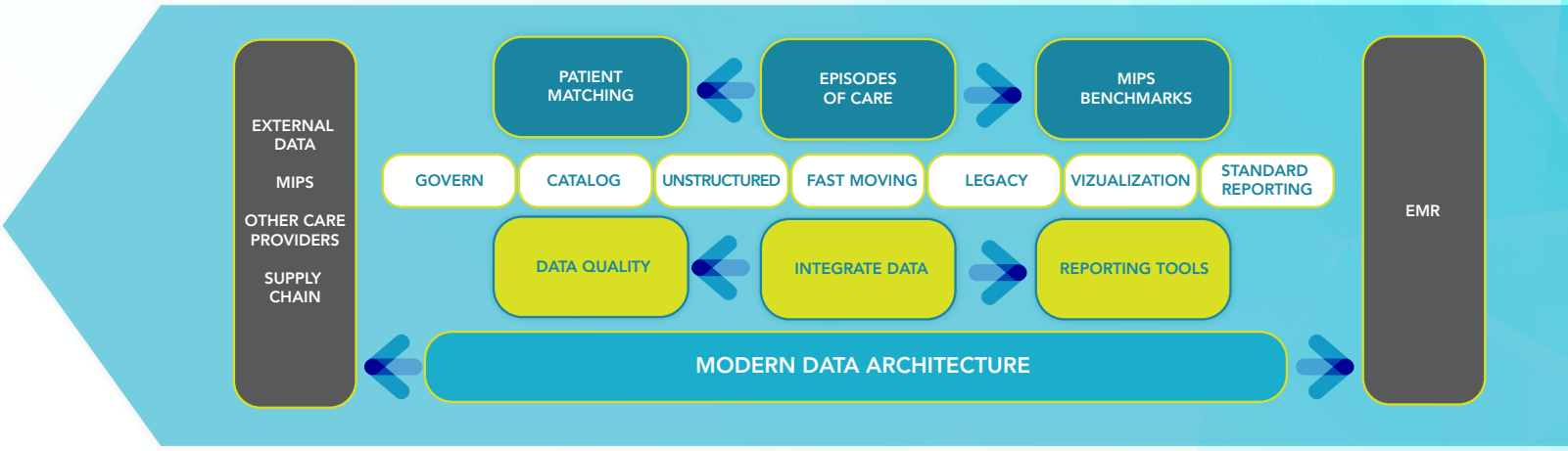
   With big data technologies, create the technical capability to quickly and easily integrate new data sources that make up your patients' health neighborhood.

4. **Implement data visualization and reporting tools**

   Ensure information is accessible in the practice and mobile situations to enable providers' real-time decision making.

5. **Establish an analytics infrastructure that complements your EMR**

   Create a data infrastructure that is complementary and not dependent on your practice's EMR.



FROM CONCEPT TO CONCRETE

Once you understand what you need to develop a modern IT data infrastructure and the long-term benefits it can provide your practice, it's time to create a true plan of action for MACRA implementation.

Beyond the technical requirements necessary for closing whatever gaps you've identified in your data architecture assessment, now is the time to think through the additional measures required to make your new strategy stick:

- Get buy-in from influencers by involving key stakeholders early in the planning process
- Create a partnership between IT and Finance that encourages cooperation and sets clear responsibilities
- Establish a well-defined objective that translates to agreed-upon business value

Only when your strategy aligns people and processes with clear business value can you expect to reap the full benefit of your data.

THE TIME IS NOW

Now is the time to make sure you are developing a MACRA strategy with a focus on the long-term benefits. This will allow you to identify issues early on and advance your performance scores over the next few years as the potential upside (and downside) grows bigger.

> The best time to plant a tree was 20 years ago. The second-best time is now."
> -Chinese Proverb

The task sounds daunting, but achieving the level of data acumen needed to properly manage MACRA implementation and respond to the evolving expectations of the industry is doable with a clear strategy in place.

If you have any questions about how to create a sustainable long-term strategy for reducing costs and increasing quality of care, please feel free to contact us.

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