MACRA & MIPS

FAQ

Key Message

Compliance can be complicated. We're here to make it easier for your practice to understand. Through this FAQ document, we hope to answer all of your questions regarding MACRA and other related compliance issues so your practice can confidently participate in these programs.

MACRA is an act that was passed in 2015. The act is still under a comment period, and it has remaining portions that are waiting to be finalized by the government. The act is anticipated to be finalized by the end of June.

MACRA is a mandatory program that is intended to set flat fee schedule updates as well as provide incentives for clinicians who provide value over volume. In addition, MACRA aims to reward high MIPS performers and dock reimbursements for low MIPS performers.

MIPS (Merit-Based Incentive Payment System) and APM (Alternative Payment Model) are the two paths clinicians can take to comply with MACRA. APM bears higher levels of both risk and reward for providers, and contains constraints; therefore, many physicians are planning to take the MIPS path to achieve compliance with MACRA.

MIPS combines several existing incentive programs: Meaningful Use (MU), Physician Quality Reporting System (PQRS), and Value-Based Payment Modifiers (VBM) into one program. The MIPS program has four components: Quality, Resource Use/Cost, Clinical Practice Improvement Activities, and Advancing Care Information.

The first MIPS payment year is 2019 and will be based on 2017 reporting data. To participate in 2017, clinicians will need to be employing an EHR software that is at least 2014 certified.

The Nextech software is 2014 certified, and Nextech is offering complimentary webinars and educational tools to help clients prepare and participate in MIPS.

FAQ

Q: **What is MACRA?**

A: MACRA stands for Medicare Access & CHIP Reauthorization Act, which passed into law in 2015. However, there are remaining parts of the act still waiting to be finalized by the federal government. Like most legislation, in which a comment period is always granted, MACRA's will continue through the end of June. Once this period concludes, MACRA is expected to be finalized and put into play this fall.

Q: **What is the point of MACRA?**

A: The MACRA legislation was passed to end the sustainable growth rate formula (SGR). For 18 years, the SGR has been used to determine Medicare payments for providers. For several years now, however, Congress has had to pass at least 17 temporary "doc fixes" to avoid cutting 21% of Medicare payments to providers. Due to the way the original law was written, it could not keep pace with the rise of healthcare costs and inflation. Instead of overhauling the system, CMS simply put temporary doc fixes in place to prevent cutting reimbursements. After many years of doc fixes, as of recently, CMS had to pass a more permanent fix in order to prevent a 21% cut in reimbursements to participating doctors. Therefore, CMS introduced MACRA to serve as a complete overhaul of the Medicare reimbursement system. MACRA is intended to set flat fee schedule updates as well as provide incentives for providing value over volume.

MACRA is intended to be a budget neutral program for CMS, one that would allow them to dock reimbursements for low performers while rewarding high performers.

Q: **What determines a high performer vs. a low performer, and what does value over volume mean?**

A: A high performer is one with an overall MIPS score that is in the top 75% of Medicare providers. Conversely, a low performer would have a score that places him/her in the bottom 25% of overall MIPS performance.

Value over volume performance will be determined by providers either participating in a high risk/high reward alternative payment system or by reporting data to CMS. To put it in simpler terms, in days past, a provider would perform a service for a Medicare patient for the specific dollar amount allotted for that service. Now, providers can continue with that preset service amount but will be required to submit data proving why they deserve the full amount. Providers can also choose to participate in a completely different payment model with high risk for a potential higher reward. See FAQs in APM below for more details on this higher risk/reward model.

Q: Is MACRA optional?

A: MACRA is not an optional program. Medicare payments will be reduced if a provider does not participate. The payment adjustment in 2019 (based on 2017 data) can be up to 4%. Each year this percentage will increase until it reaches the capped maximum of 9% in 2022 and beyond.

Q: Since I must participate in MACRA, how can I comply with the least amount of change to my overall practice?

A: To fulfill MACRA, providers can choose one of two paths: Advanced APM (Alternative Payment Model) or MIPS (Merit-Based Incentive Payment System) and report the data.

Q: What is APM?

A: APM is a new way for Medicare to pay healthcare providers for the care they provide for Medicare beneficiaries. Only certain APMs are considered advanced APMs due to additional requirements. Advanced APMs are required to bear more than nominal financial risk. An example that would meet this criterion could be a two-sided shared saving arrangement that would consist of:

- If the APM Entity's actual expenditures exceed expected expenditures (the benchmark), then the APM Entity must pay CMS 60% of the amount of expenditures that exceed the benchmark.
- The APM Entity does not have to make any payments if actual expenditures exceed the benchmark by less than 2% of the benchmark amount.
- There is a stop-loss provision so that the APM Entity could pay up to but no more than a total amount equal to 10% of the benchmark.

So the benefit to participating is exclusion from MIPS, plus CMS will give a 5% lump sum bonus 2019 to 2024. Also, there would be higher fee schedule updates for these participants starting in 2026. Due to these constraints, many physicians are likely to take the MIPS path instead of APM.

Q: What is MIPS?

A: MIPS will combine several existing incentive programs, Meaningful Use EHR Incentive Program (MU), Physician Quality Reporting System (PQRS), and Value-Based Payment Modifiers (VBM), into a single program. MIPS has 4 components added together to give providers a grand total composite score which is what their payment adjustments will be based on. Let's briefly break down how the MACRA proposal defines each component:

1. **Quality** – formerly PQRS. Counts for 50% of total MIPS score. CMS is proposing requiring physicians to report on 6 measures instead of 9. However, for 2017 at least, they are sticking with the existing measures available. There is also potential to earn extra credit to help providers attain the maximum points for this category by reporting on high priority measures.
2. **Resource Use/Cost** – formerly Value Based Payment Modifier (VBM). Counts for 10% of total MIPS score. This will be based entirely on a provider's claims data, so no additional requirements are needed to be fulfilled.
3. **Clinical Practice Improvement Activities** – new category. Counts for 15% of total MIPS score. Allows offices to participate in specific tasks, which can be selected from a list over 90 potential activities. These include things like telemedicine, participating in bi-lateral exchange of health data with structured referral notes, and regularly assessing patient experiences via surveys and advisory councils, etc.
4. **Advancing Care Information** – formerly MU. Counts for 25% of total MIPS score, but this rate may decrease in the future. The proposal includes requiring a 50-point base score for reporting 6 measures with yes/no or numerator/denominator and an 80-point performance score. Due to the calculation of this category, there is no longer an all-or-nothing approach. Credit is still given for partial completion. For instance, if providers only have 1 patient view, download, or transmittal of data, they could still earn the base score but will have a lower performance score for this measure. The proposed 6 objectives are as follows:
    1. Protect patient health information
    2. e-Prescribing (eRx)
    3. Patient electronic access
    4. Coordination of care through patient engagement
    5. Health information exchange
    6. Public health registry reporting (potential to earn extra credit)

As for the reporting of all of this data, that will be very similar to report PQRS and MU in the past with pulling from your claims, manual attestation, registries, etc...

REMINDER: for the Advancing Care Information component (formerly MU), providers will need to continue participation in and reporting with the Meaningful Use Modified Stage 2 requirements for all of 2016 and 2017. Also, for the Quality (formerly PQRS) and Resource Use/ Cost (formerly VBM) categories, providers will need to continue participation in and reporting with the PQRS requirements for all of 2016 and 2017.

It is important to note that, as of 2017, CMS will do away with the shortened 90-day reporting period for first-timer MU participants. The only leniency they are providing is first year of Medicare Part B participation or low patient volume threshold (less than $10,000 AND fewer than 100 Medicare patients in 1 year), which are excluded from MIPS. All other clinicians (currently reporting and new to reporting)

have to report for the entire year. Again, since there is partial credit, providers can report all data for the year (even if only a few months) and still eek out with at least *some* Advancing Care Information credit.

Q: Can I participate in one program and then switch to the other mid-way?

A: Yes. CMS is trying to encourage participation in APMs. Providers can start out on MIPS and switch over to APMs at a later date.

Q: What is the timing of participating in MIPS or APM?

A: The first MIPS payment year is 2019 which will be based on your 2017 reporting data. That means this year (2016) is the year to make sure you are optimizing your performance. The timeline for participation in APM has already begun. The following programs are already Advanced APMs and more are being added to the list each year:

- Shared Saving Program (SSP) (track 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 track available in 2018)

Q: Does this impact all eligible providers?

A: CMS has stopped using the term EPs (eligible professionals) and started using ECs for eligible clinicians. That may not seem like a big change, in and of itself, but it is. It is no longer only the MDs reporting in the Advancing Care Information category (formerly Meaningful Use), but everyone—including PAs, NPs, and others who are considered Medicare Part B providers will also be participating. Luckily, CMS is granting an exclusion for the first year for clinicians that were not previously required to report (PAs, NPs, etc.). However, they will still be participating in the future. This means that now is the time to start thinking about what changes are needed in your office.

Q: What is the reporting period for MIPS?

A: MIPS goes into effect for 2017 data. Therefore, for the remainder of 2016, all providers will continue to report each program separately (MU, PQRS, etc.) just as they did in 2015, and submit their 2016 data by February of 2017 at the latest. In 2017, eligible clinicians will need to report a full year's worth of data from the aforementioned four categories by February of 2018.

Q: Does my software have to be 2014 or 2015 (aka MU3) certified for me to participate in MIPS?

A: To participate in MIPS for 2017, a clinician's EHR software is required to be 2014 or 2015 certified. It is important to note that no EHR has yet been 2015 certified. CMS and ONC still have some details to hammer out before granting 2015 certifications. When the finalized MACRA rule is published in the fall of this year, we can anticipate more details to be provided on the current gray areas of 2015 certification.

It is important to note that, starting in 2018, eligible clinicians will be required to use the 2015 certified software which was previously known as MUS3 (Meaningful Use Stage 3).

Q: Is the Nextech software certified for me to use to participate in MIPS?

A: Yes. Nextech's software products are 2014 certified. Details below are from http://oncchpl.force.com/ehrcert:

Product	Version	Classification	Edition	Vendor	CHPL Product Number
Nextech with NewCropRx	11.3	Complete EHR	2014	Nextech Systems Inc.	140157R00
Nextech with NewCropRx	11.4	Complete EHR	2014	Nextech Systems Inc.	140157R01
Nextech with NewCropRx	11.5	Complete EHR	2014	Nextech Systems Inc.	140157R02
Nextech with NewCropRx	11.6	Complete EHR	2014	NextechSystems Inc.	140157R03
Nextech with NewCropRx	12.0	Complete EHR	2014	NextechSystems Inc.	140157R04
Nextech with NewCropRx	12.1	Complete EHR	2014	NextechSystems Inc.	140157R05
Nextech with NexErx	11.3	Complete EHR	2014	NextechSystems Inc.	140137R00
Nextech with NexErx	11.4	Complete EHR	2014	NextechSystems Inc.	140137R01
Nextech with NexErx	11.5	Complete EHR	2014	NextechSystems Inc.	140137R02
Nextech with NexErx	11.6	Complete EHR	2014	NextechSystems Inc.	140137R03
Nextech with NexErx	12.0	Complete EHR	2014	NextechSystems Inc.	140137R04
Nextech with NexErx	12.1	Complete EHR	2014	NextechSystems Inc.	140137R05
IntelleChart	6.5	Modular EHR	2014	MDIntelleSys, LLC	03062014-2428-9
IntelleChart	6.6	Modular EHR	2014	MDIntelleSys, LLC	06262014-2429-9

Q: What is Nextech's recommendation on how to use its software products to help me comply with MIPS?

A: For the Quality category, you should utilize your current PQRS reporting method by completing the existing data points within the patient record. The recommended methods include the following items:

- IRIS Registry
- DataDerm Registry
- Direct EHR to generate and upload QRDA III

For the Resource Use/Cost category, CMS will automatically take the data needed from your claims. No additional requirements are needed.

For the Advancing Care Information category, you should continue to utilize the software to document your electronic prescriptions, clinical summaries, demographics, patient educational resources, and more.

For the Clinical Practice Improvement Activities category, CMS is still finalizing the details on this and should have more information on how to achieve this in the fall season (following the end of the summer comment period).

Q: Can Nextech help me optimize my performance, as well as my mid-level providers' performance, so I am ready at the start of 2017?

A: Yes. Nextech has a series of helpful and fully complimentary webinars available on our community portal. To access, please visit https://nextechsupport.force.com/customer/a11?fcf=00B33000007AaY3.

If clients may need a more 1-to-1, hands-on approach, we will also be offering online and onsite MIPS Optimization packages in Q4 of 2016.

Q: What do I need to be doing between now and January 1 2017 to comply with MIPS?

A: Between now and 2017, you should make sure to do the following:

1) Try your best to achieve high performance in your current Meaningful Use and PQRS measures, as this will help you have a higher MIPS score in 2017.

2) You should prepare providers who were not previously required to report for future reporting (PA's, NP's, etc.).

3) If you have not started participating in the existing programs (MU & PQRS), do not delay any further! You should start as soon as possible to ensure that all of your processes are in place and your staff is properly trained. This will give you the best shot at being among the higher (and thus better rewarded) MIPS performers.