LSMS FIVE-STEP MACRA CHECKLIST

Steps you can take NOW to prepare your practice.

The Centers for Medicare & Medicaid Services (CMS) finalized policies to implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) on Jan. 1, 2017. Under the new law, CMS has designed a new Quality Payment Program that has two paths: the Merit-Based Incentive Payment System (MIPS) and advanced alternative payment models (APMs). For the first year of the new Quality Payment Program, CMS created a "transition year" and offers a pick your pace approach to participation along with many flexibilities to allow you to build capabilities to report and gain experience with the new program. In 2017, you may participate in an advanced APM or submit data under the MIPS program for a full year, partial year, or test the system by submitting a minimum amount of data for any point in time to avoid a penalty. If you choose not to participate in either path in 2017, you will receive an automatic 4% pay cut on a per claim basis to your Medicare Part B payments in 2019.

Here are five steps the Louisiana State Medical Society (LSMS) recommends you take to prepare your practice:

1. LEARN ABOUT THE NEW *QUALITY PAYMENT PROGRAM* AND SELECT THE PATH BEST SUITED FOR YOUR PRACTICE
2. ASSESS YOUR PERFORMANCE UNDER MEDICARE'S CURRENT QUALITY PROGRAMS
3. REVIEW AND SELECT QUALITY MEASURES AND REPORTING MECHINISIMS
4. CONTACT YOUR EHR VENDOR, AND REVIEW AND SELECT *ADVANCING CARE INFORMATION* (ACI)MEASURES
5. REVIEW AND SELECT PRACTICE IMPROVEMENT ACTIVITIES AND REPORTING MECHINISIMS

Confused by all the acronyms? Check out LSMS' MACRA Glossary (last page)

Step 1: Learn about the new Quality Payment Program and select the path best suited for your practice.

To learn about MIPS and APMs, visit lsms.org/MACRA to access educational resources, and tools from the LSMS, your national specialty society, the American Medical Association, and other trusted sources. Determine if an APM or advanced APM is an option for your practice in 2017. If you are currently in an APM and are not sure where you stand, contact your APM administrator. If you decide to take part in an advanced APM, you may earn a 5% Medicare incentive payment for participating in an innovative payment model. If you are not in an APM or if you are in an APM that is not classified as an "advanced APM," you will be paid fee-for-service with incentives or penalties under the new MIPS program.

- Before you begin, consider whether you are exempt from MIPS participation. CMS will exempt physicians from MIPS in 2017 if they are in their first year of Medicare Part B participation, part of an advanced APM, or are below the low-volume threshold of $30,000 or less in Medicare Part B charges and 100 or fewer Medicare Part B enrolled beneficiaries annually. To determine if you are below the low-volume threshold and excluded from MIPS in 2017, access the NPI level lookup tool on the new Quality Payment Program website. This feature should be made available before or shortly after the start of the performance period.

- If you are not exempt, determine what a 4% bonus or penalty to your Medicare payment in 2019 means to your practice and bottom line. As you learn about MIPS requirements, consider your potential practice costs and effort to comply with each MIPS category in 2017. For some practices, simply taking the penalty may be less costly than attempting the compliance and reporting requirements.

- If MIPS compliance and reporting is right for your practice, prepare to participate in the new program. For the first performance period, CMS reweighted the four MIPS performance categories and reduced the cost category weight to zero. In 2017, performance measurement will be based on three weighted categories.

- Note: These weights are default weights and can be adjusted in certain circumstances. Although the cost category will not count in the first year, CMS will still provide feedback on how you performed on cost measures using information obtained from administrative claims data, but it will not affect your performance score in 2017 or your payment in 2019.

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- The resulting weighted performance category scores would be summed to create a single composite performance score on a zero to 100 point scale in 2017. That score would then determine whether you receive a Medicare payment bonus, penalty, or neither in 2019. In 2017, the performance threshold was set really low at just three points. Per CMS, you must score three or more points to avoid a penalty, four to 69 points to receive an incentive payment, and 70 points or greater to receive an incentive payment plus an exceptional performance bonus.

- In 2017, the majority of physicians will fall under MIPS. For the first performance period, MIPS will apply to physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists, which CMS collectively refers to as "eligible clinicians." Physician means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery, doctor of dental medicine, doctor of podiatric medicine, or doctor of optometry, and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.

- As you learn about MIPS requirements, determine if you will report individually or as a group. For the transition year, CMS offers a pick your pace approach to participation and you may submit data under the MIPS program for a full year (12 months), partial year (90 continuous days), or test the system by submitting a minimum amount of data for any point in time to avoid a penalty. A minimum amount of data means reporting data on one quality measure, or one improvement activity, or four or five measures that are required for the base score of the ACI category depending on the edition of your certified electronic health record (EHR) technology. However, the more data you submit, the greater the potential for a higher performance score and bonus payment.

- The data submission timeframe to report all data for the 2017 MIPS performance period is January-March 2018, but you must collect the data during the performance period or prior to the submission timeframe. Data collection and submission requirements and deadlines vary by reporting mechanism. If you choose not to submit any data for the first performance period, you will receive an automatic 4% penalty in 2019.

Step 2: Assess your performance under Medicare's current quality programs.

MIPS replaces and will include similar concepts from the Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VM) program, and EHR Incentive Program (meaningful use). The transition to MIPS may be easier if you are already familiar with the current CMS quality programs. Assess your performance under these programs and, as you learn about MIPS requirements, determine what changes you will have to make in your practice to meet the requirements for each MIPS category.

- The quality category is similar to PQRS, the cost category is similar to the VM program, the ACI category replaces the meaningful use program, and the improvement activities category is a new performance requirement.

- If you participate in the PQRS and VM programs, and if you have not already reviewed your reports, get to know the type of feedback CMS provides and the data it uses to assess your quality and cost performance. For the PQRS program, access your PQRS feedback report; for the VM program, access your quality and resource use report (QRUR).

- Analyzing your feedback reports will help you prepare for the quality and cost categories in MIPS. Consider which practice strategies you could implement to optimize performance and improve your scores in 2017. Past reports are available to you at any time; reports for the 2015 PQRS and VM performance period were released in September 2016 and are available now.

Step 3: Review and select quality measures and a reporting mechanism.

You may report data on quality measures for MIPS in the same way you have reported data to PQRS. The majority of the quality measures for MIPS have previously been utilized in PQRS for many years. However, CMS has reduced the required number of quality measures to six measures in 2017, down from nine measures in 2016. For the transition year, you have greater flexibility to determine the most meaningful measures and reporting mechanism for your practice.

- To test the system and report a minimum amount of data in 2017 to avoid a penalty in 2019, you only need to report data on at least one quality measure via one of the six quality reporting mechanisms noted below.

- For full year or partial year participation, and when reporting data on quality measures via claims, qualified registry, qualified clinical data registry (QCDR), or EHR, you must report on at least six quality measures from either the list of MIPS individual measures or a specialty measure set (measures are the same in both lists). One of the six measures must include at least one outcome measure, or if an outcome measure is not available, then choose another high-priority measure defined as appropriate use, patient safety, efficiency, patient experience, and care coordination measures. If fewer than six measures apply, then you are only required to report on each measure that is applicable. In addition to the six measures, the readmission measure is included for group reporting with groups with at least 16 eligible clinicians and sufficient cases, and this information will be obtained from administrative claims data.

- The web interface reporting mechanism requires reporting on up to 15 measures for a full year. Reporting patient experience data via a Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey is optional and will count as one of your six quality measures. These two methods require registration with CMS by June 30, 2017 for the 2017 performance period.

- In general, you will receive three to 10 points on each quality measure based on performance against benchmarks. Note that there are separate benchmarks for different reporting mechanisms and that not all measures will have a benchmark. If there is no benchmark for a measure, then you only receive three points for that measure. The maximum number of points

is 60 or 70 points for most reporting mechanisms, or 110 or 120 points if you report via web interface. Bonus points are available for reporting on additional high-priority measures or for using certified EHR technology to submit measures to registries/QCDRs or CMS. Physicians who receive the maximum score will receive the full quality category weight of 60 percent towards their MIPS composite performance score.

- To review and select measures for the MIPS quality category, review the list of 271 quality measures on the Quality Payment Program website. Take note of each quality measure's type and data submission method. In addition, review each measure's 2017 specifications and documentation requirements, as well as measure benchmarks once published by CMS. This process should be conducted annually to ensure accurate reporting. In selecting measures to report, keep in mind that simply reporting data on quality measures will not be sufficient to earn a high score. Reporting is necessary, but how well you perform on each quality measure is what will control your score.

- Next, determine which reporting mechanism will best fit your practice. In 2017, if you report individually, you may report via QCDR, qualified registry, EHR, and claims. If you report as a group, you may report via QCDR, qualified registry, EHR, web interface (for groups with 25 or more), administrative claims, and CAHPS for MIPS survey. Since CMS has not yet posted guidance for these reporting mechanisms for the first MIPS performance period, start by reviewing the existing reporting mechanisms under the PQRS program: Medicare Part B claims, registry, QCDR, EHR, web-interface, and CAHPS surveys.

- Know the data completeness/reporting threshold requirements for your reporting mechanism of choice. For registry, QCDR, or EHR reporting mechanisms, CMS requires that you report on 50 percent of your patients across all payers. For claims, CMS requires that you report on 50 percent of Medicare Part B patients. For web interface and the CAHPS for MIPS survey, CMS provides sampling requirements for Medicare Part B patients.

- Population health or panel management, care coordination, and other clinical activities relevant to your specialty and patient population will be key strategies to help you improve your patient outcomes and overall quality score. To optimize performance, align care plans, target care delivery, and/or redesign clinical workflows, and train your staff in advance so that everyone on your care team is on board to excel on each quality measure in 2017. If possible, leverage your health information technology and data analytics capabilities to monitor your patient outcomes and quality performance within the 2017 performance period, and make adjustments to care delivery as needed.

Step 4: Contact your EHR vendor, and review and select ACI measures.

The ACI category of MIPS replaces the current meaningful use program that requires physicians to attest annually on meeting certain measures prescribed by CMS. Contact your EHR vendor to inquire about its MIPS readiness plan, if you are able to streamline all of your reporting requirements for each MIPS category through its product, and how the vendor can help you be successful in MIPS.

- To meet the requirements of the ACI category, an EHR is required. If you do not currently use an EHR, you will have to select, purchase, and implement an EHR. Be sure the product you select is certified.

- If you currently use a certified EHR, check with your EHR vendor to ensure the product you use will be upgraded to meet the metrics required. As vendors upgrade, the product must be certified. The next upgrade will be to the 2015 certification criteria, which is optional in 2017 and required in 2018. Visit lsms.org/MACRA to view the list of certified products.

- Review and select ACI measures. In 2017, physicians will need to meet four or five measures required for the base score, and can earn performance and bonus points to earn the full ACI score. Physicians who earn 100 ACI points will receive the full ACI category weight of 25 percent towards their MIPS composite performance score. This is important for physicians seeking an incentive payment in 2019 which is based upon 2017 performance.

- To test the system and report a minimum amount of data in 2017 to avoid a penalty in 2019, you only need to attest to four or five measures that are required for the base score depending on the edition of your certified EHR technology. To determine the number of measures your edition requires, review the criteria on the Quality Payment Program website. Other options for penalty prevention include reporting one quality measure or one improvement activity as previously noted.

Step 5: Review and select improvement activities and reporting mechanism.

The improvement activities category is a new performance requirement. In 2017, there are 92 activities to choose from across nine subcategories, which include: achieving health equity, behavioral and mental health, beneficiary engagement, care coordination, emergency response and preparedness, expanded practice access, patient safety and practice assessment, population management, and participation in an APM.

- The required number of improvement activities you must attest to varies from one to four activities depending on each activity's weight and your practice model, size, and location. In general, medium-weighted activities are worth 10 points and high-weighted activities are worth 20 points. Physicians who receive a total of 40 points will receive the full improvement activities category weight of 15% towards their MIPS composite performance score.

- To review and select activities for the improvement activities category, review the list of 92 improvement activities on the Quality Payment Program website. Identify improvement activities your practice already does and will continue to do in 2017, and which activities your practice could implement to receive credit for the first performance period. If you don't already engage in any activities on the list, identify improvement activities that fit your practice and prepare to engage in or implement them in time for the first performance period. Note that you are not required to perform activities in each subcategory in order to receive the highest possible score.

- To test the system and report a minimum amount of data in 2017 to avoid a penalty in 2019, you only need to attest to one improvement activity regardless of its weight.

- For full year or partial year participation, you may choose up to four improvement activities for a minimum of 90 days each. Choose one of the following combinations: two high-weighted activities or one high-weighted activity and two medium-weighted activities.

- For solo physicians and groups with fewer than 15 eligible clinicians, rural practices or practices located in geographic health professional shortage areas, and non-patient facing eligible clinicians, you may choose up to two activities for a minimum of 90 days each. Alternate activity weights are applied to physicians who fall under these designations. Medium-weighted activities are worth 20 points and high-weighted activities are worth 40 points. For full year or partial year participation, choose one of the following combinations: one high-weighted activity or two medium-weighted activities. To confirm your eligibility for these reduced requirements, contact the Quality Payment Program Service Center at (866) 288-8292.

- Physicians who participate in APMs automatically earn full or half credit. Refer to the Quality Payment Program website for these details.

- To report improvement activities to CMS, you may attest that you completed improvement activities via qualified registry, QCDR, EHR, health IT vendor, attestation, and/or administrative claims. To streamline your MIPS reporting, consider aligning your reporting mechanism with the same data submission method used for the other categories.

- Make sure you have documented policies and procedures in place to document improvement activities you are already doing, or plan to do, in the future.

What to Expect After You Submit Data to MIPS

- Prepare your practice for potential audits. CMS will selectively audit physicians and other eligible clinicians annually to conduct "data validation and auditing" of any data submitted under MIPS. Review your documentation and ensure EHR templates are used with care and that data fields in either EHR and/or paper charts clearly capture the documentation required to support each measure. Prepare to keep a record of which patients you report on per measure and performance period so that your practice can identify medical records easily if you are selected for an audit.

- CMS will provide performance feedback to you sometime in 2018. Monitor the Quality Payment Program website for information about feedback reports, exact time frames, and access and download your report as instructed by CMS. The report will include information about your quality and cost performance and whether you will receive a bonus, penalty, or neither in 2019. For issues identified in your report, prepare to file a request for a targeted review to appeal errors and/or MIPS penalty by the CMS deadline.
- Know that all MIPS data will be subject to public reporting on the Physician Compare website. This website, which is open to the public, reports information about physicians and other health care professionals who take part in Medicare and satisfactorily participate in CMS quality programs. Check your profile and make sure it is up-to-date. For more information, visit the CMS Physician Compare website.

Where to Find Help

- Monitor lsms.org/MACRA as we will continue to provide updates, new educational tools and other pertinent information as it becomes readily available.

- LSMS recommends you monitor the Quality Payment Program website for new fact sheets, guides, education, resources, and tools for in-depth guidance on how to accurately collect and submit data for each MIPS category for the 2017 performance period. For questions, contact the Quality Payment Program Service Center at (866) 288-8292. Additionally, know that CMS intends to change several requirements for each MIPS category for the 2018 performance period and subsequent years, so stay abreast of program changes annually. Visit lsms.org/MACRA for the latest information and where you can find additional resources and assistance to help you transition to the new Quality Payment Program.

MACRA GLOSSARY

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MACRA (Medicare Access and CHIP Reauthorization Act of 2015): 2015 law that repealed the sustainable growth rate formula for determining Medicare payments and created two new performance-based payment tracks: the Merit-Based Incentive Payment System and alternative payment models.

SGR (Sustainable Growth Rate): Former Medicare formula to calculate physician fee-for-service payment rates. Repealed by MACRA.

MIPS (Merit-Based Incentive Payment System): One of two payment tracks under MACRA. MIPS consolidates the Centers for Medicare & Medicaid Services' Physician Quality Reporting System, Value-Based Payment Modifier Program, and Electronic Health Records Incentive Programs into one single program starting in 2019.

APMs: (Alternative Payment Models): One of two payment tracks under MACRA. Examples include accountable care organizations, patient-centered medical homes, bundled payment models, and other initiatives.

PQRS (Physician Quality Reporting System): Medicare program asking physicians to document and report on clinical quality measures. Scores feed into the Value-Based Payment Modifier Program.

VM (Value-Based Payment Modifier): Medicare calculation to adjust physician fee-for-service payments either up or down based on how they perform on quality and cost factors.

MU (Meaningful Use): Refers to meaningful use of electronic health records, which is the objective of the Centers for Medicare & Medicaid Services' Electronic Health Records Incentive Programs.

CPIA (Clinical Practice Improvement Activity): A new Medicare performance category that may help physicians gain some credit under MIPS. CPIA subcategories are expanded access, population management, care coordination, patient engagement, patient safety and practice assessment, and transition to or participation in an alternative payment model. New rules will define the criteria.

QCDR (Qualified Clinical Data Registry): An entity approved by the Centers for Medicare & Medicaid Services that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients.

CAHPS: Consumer Assessment of Healthcare Providers and Systems Patient satisfaction and experience surveys.

QRUR (Quality and Resource Use Report): Medicare feedback reports on physicians' quality and resource use (cost) scores and how their performance compares with that of their peers.

ACO: Accountable care organization

AF: Adjustment factor

APMs: Alternative payment models

CAHPS: Consumer Assessment of Healthcare Providers and Systems

CEHRT: Certified electronic health record technology

CHIP: Children's Health Insurance Program

CMMI: Center for Medicare & Medicaid Innovation

CMS: Centers for Medicare & Medicaid Services

CPIA: Clinical practice improvement activity

CQM: Clinical quality measures

EHR: Electronic health record

EIDM: Enterprise Identity Management System

EP: Eligible professional

FFS: Fee-for-service

MSPB: Medicare spending per beneficiary

MIPS: Merit-Based Incentive Payment System

MPFS: Medicare Physician Fee Schedule

MSSP: Medicare Shared Savings Program

MU: Meaningful use

NPI: National Provider Identifier

PCMH: Patient-centered medical home

PECOS: Provider Enrollment, Chain, and Ownership System

PFPM: Physician-focused payment model

PQRS: Physician Quality Reporting System

QCDRs: Qualified clinical data registries

QP: Qualifying alternative payment model participant

QRUR: Quality and Resource Use Report

TIN: Taxpayer Identification Number

VM: Value-Based Payment Modifier Program