MACRA ROADMAP

The Medicare Access and CHIP Reauthorization Act or MACRA repeals the Sustainable Growth Rate (SGR) Formula and replaces it with the Quality Payment Program (QPP), rewarding providers based on the quality of care they provide to their patients. Providers billing Medicare Part B can choose to participate based on the two available pathways:

1. Merit-Based Incentive Program (MIPS): MIPS streamlines multiple quality reporting programs - PQRS, Value-Based Modifiers and Meaningful use program into a single program. Based on their performance in 2017, providers participating under MIPS would receive payment adjustments ranging from -4% to 4% in 2019.
2. Advanced Alternative Payment Model (Advanced APM): Qualifying participants under Advanced APMs would receive lump sum 5% incentive in 2019.

Due to the enormous amount of information available on MACRA, which is complex as well as and puzzling, the providers face dilemma of where to begin. Below roadmap will help to simplify the shift for you:

Step 1: Determine Your Eligibility

Physicians, Physician Assistants, Nurse Practitioners, Clinical Nurse Specialist, Certified registered Nurse Anesthetist who bill Medicare more than $30,000 a year and provide care for more than 100 Medicare beneficiaries a year are eligible for MIPS adjustments. You must meet both the minimum billing and the number of patients to be in the program. If you are in your first year of Medicare, below the low-volume threshold, or are a qualifying participant under an Advanced Payment Model, you are exempted from MIPS.

The first step towards MIPS is to review your previous year's revenue and patient volume to determine your eligibility.

Step 2: MIPS or Advanced APM?

An Alternative Payment Model (APM) is a payment approach, developed in partnership with the clinician community that provides added incentives to clinicians to provide high quality and cost-efficient care. Advanced APMs are a subset of APMs and let practices earn more for taking on some risk related to patients' outcomes. CMS has published the list of Advanced APMs for 2017.

If you are a part of any of the following APMs, you are an Advanced APM participant:

- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Shared Savings Program - Track 2
- Shared Savings Program - Track 3
- Oncology Care Model (OCM) - Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

Being a part of Advanced APM does not guarantee 5% payment adjustments. To be a qualifying participant, you need to see at least 20% of your Medicare patients and receive at least 25% of your Medicare Part B payments through and Advanced APM. If you do not meet the low-volume threshold to qualify as a QP (Qualifying Participant) you would be part of MIPS APM. Certain other APMs that include MIPS eligible clinicians as participants and hold their participants accountable for the cost and quality of care provided to Medicare beneficiaries are also part of MIPS APM. Participants under MIPS APM are scored differently. The lists of MIPS APMs for 2017 are:

- Medicare Shared Savings Program Accountable Care Organizations - Tracks 1, 2 and 3
- Next Generation ACO Model

- Comprehensive ESRD Care (CEC) Model (LDO arrangement, non- LDO arrangement one-sided risk arrangement, non- LDO two-sided risk arrangement)
- Oncology Care Model (OCM) (one-sided risk arrangement and two-sided risk arrangement)
- Comprehensive Primary Care Plus (CPC+) Model

Even if you were a part of Advanced APM, you would not know until almost the end of the year whether you meet the threshold for being a Qualifying APM Participants. It is therefore advisable to prepare for MIPS under the MIP APM Scoring Standard.

Step 3: Gauge Your Readiness and Choose How You Want to Start

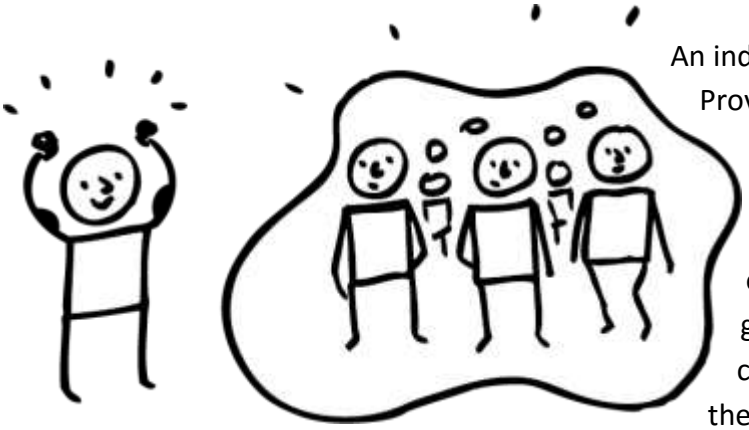
For the transition year 2017, you have an option to pick your pace:

- Do not participate and receive full -4% payment adjustment in 2019
- Submit some data and avoid payment adjustment
- Submit 90 days data and receive neutral or positive adjustment
- Submit full year data and receive positive adjustment

Some of the factors that would help you take this decision are:

- Do you use an ONC certified EHR? Have you participated in PQRS or Meaningful use incentive in the previous years? If yes, you are ready to go for a full year submission and receive the maximum positive adjustments.
- If you are not using and EHR or your EHR is not certified, this is the right time to go for a certified EHR. You will still be able to submit 90 days data and get a modest positive adjustment.
- Find out from your EHR vendor for which Edition of ONC Certification they are certified. For 2017, you can use both 2014 Edition and 2015 Edition Certified EHR, but from 2018, you have to use 2015 Edition Certified EHR. If your EHR is not 2015 Edition certified, find out from your vendor the timeline they plan to upgrade their certificate.

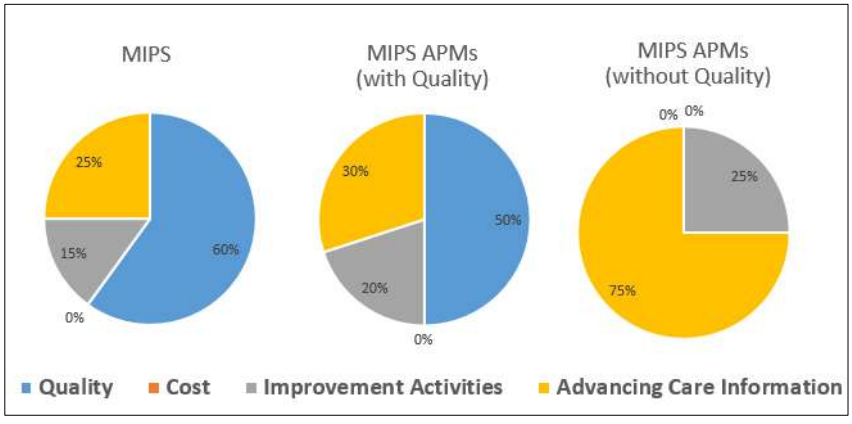
Step 4: Choose Whether You Will Report as an Individual or a Group



An individual is defined as a single National Provider Identifier (NPI) tied to a single Tax Identification Number. If you submit your data as an individual, you will receive adjustments based on your individual performance. A group is defined as two or more clinicians (identified by the NPI) sharing the common Tax Identification Number. If you submit your data as group, each clinician within the group would receive the adjustments based on the group's performance.

Step 5: Work towards Improving Your MIPS Score

Under MIPS, you would be scored on four performance categories: Quality, Cost, Improvement Activities and Advancing Care Information. Each of these categories is assigned a weightage to arrive at the final composite MIPS score. For 2017, Quality is given the weightage of 60%, Improvement Activities 15% and Advancing Care information 25%. Cost would not be scored in 2017. These weightages differ for MIPS APMs. MIPS APMs that require their APM entity to submit Quality data through the CMS web interface are weighted 50% on Quality, 30% on Advancing Care information and 20% on Improvement Activities.



MIPS APMs that do not require their entities to submit quality data are weighted 25% on Improvement Activities and 75% on Advancing Care Information.

Quality Performance Category: This was formally the PQRS quality reporting. If you have participated in PQRS or Meaningful use incentive programs in the previous years, you can compare your past performance rates on each of the PQRS measures or the CQM under Meaningful use against their respective benchmarks published by CMS. This will give you a good idea of what your score would be for 2017 under similar performance. This will guide you to select the best measures, set targets and work towards achieving those. Ensure that you select at least one outcome or a high priority measure. Once you have selected the measures and set your targets, you need to monitor your progress periodically.

Advancing Care Information: This was formally the Meaningful use Incentive Program. If you are using 2014 Edition certified EHR, you can report on the 2017 Advancing Care Information Transition Objectives and Measures. If you are using a 2015 Edition or combination of 2014 and 2015 Edition certified EHR, you can report on either the Advancing Care Information Objectives and Measures or the 2017 Advancing Care Information Transition Objectives and Measures. Again, based on your previously submitted performance rates, you can estimate your ACI score for 2017 and work towards improving them.

Improvement Activities: This is a new performance category. There are around 93 high and medium weighted activities and you need to perform up to four activities for a period of 90 days to achieve the maximum score of 40. If you are a group of 15 or less providers, non-patient facing clinicians or serve in rural or health professional shortage area, you need to perform up to two activities. If you are part of a certified patient-centered Medical Home or certain APMs, you automatically receive full credit. Participants of the Improvement Activity Study also receive full credit.

If you do not fall under the MIPS APM, patient-centered Medical Home and have not applied for the Improvement Activity Study, you will have to report on this performance Category. Certain activities can be performed using a certified EHR and earns bonus points under Advancing Care Information. Some of the activities like those related to chronic care management and Tele-medicine can open up additional revenue options. Keeping these facts in mind, review the list of the available activities and select those that not only help you achieve the required score, but also help to improve the quality of care.

Step 6: Choose Your Data Submission Method

There are several data submission methods available – attestation, claims, and submission through EHR, Qualified Registry, Qualified Clinical Data Registry (QCDR) and web-based interface. You can report on all the categories through the same method or use different methods for each category. Keep the following points in mind while selecting the submission method for Quality:

- Different quality measures have different submission methods. For example, Measure ID 1: Diabetes: Hemoglobin A1c (HbA1c) Poor Control can be submitted through any of the methods Claims, CMS Web Interface, EHR or Registry, whereas Measure ID 163: Diabetes: Foot Exam can be submitted only through EHR and Measure IDs 416 and 417: Diabetes Mellitus: Diabetic Foot and Ankle Care can be submitted through registry only.
- The Benchmarks for the same measure are different for different the submission methods. For example, for Measure ID 1: Diabetes: Hemoglobin A1c (HbA1c) Poor Control, performance rate of 7% would fetch you a score of 8 if you submit though EHR, 9 points on claim submission and full 10 points if you submit through a Qualified Registry or QCDR.
- Not all EHR support all the measures
- Not all Qualified Registries or QCDRs are qualified for all the measures

First, you need to assess which data submission method would fetch you the highest score for your selected measure. If you are submitting through your EHR, you need to determine whether your EHR supports your selected measures. If not, consider going through a Qualified Registry or QCDR, which is qualified to submit your chosen measures.

Step 7: Review Your Quality and Resource Use Reports (QRUR)

Value based Modifier is replaced with the Cost Performance Category of MIPS. There are no reporting requirements for this category, as CMS would calculate the score based on your claims. Although Cost performance category will not be scored this year, it is highly advisable that you obtain your QRUR reports. QRUR reports are available from https://portal.cms.gov. You will need to create an EIDM (Enterprise Identity Management System) account to download the QRUR, if you do not have one already. You may review your current Total per capita costs for all attributed beneficiaries, Medicare Spending per Beneficiary (MSPB) and your performance on the episode-based measures to access where you stand today and what steps you need to take to better position yourself in 2018.

About iPatientCare:

iPatientCare, Inc. is a privately held medical informatics company based at Woodbridge, New Jersey. The company's unified product suite includes Electronic Health/Medical Record and integrated Practice Management/Billing System, Patient Portal/PHR, Health Information Exchange (HIE), and Mobile Point-of-Care Solutions for both Ambulatory and Acute/Sub-acute market segments. iPatientCare has been recognized as a preferred MU partner by numerous Regional Extension Centers (REC), hospitals/health systems, and professional academies.

iPatientCare is also an approved MIPS 2017 Qualified Registry

iPatientCare EHR 2014 (2.0) has received 2014 Edition Ambulatory Complete EHR certification by ICSA Labs, an Office of the National Coordinator-Authorized Certification Body (ONC-ACB), in accordance with the applicable eligible professional certification criteria adopted by the Secretary of Health and Human Services (HHS).

Full certification details can be found at ONC Certified Health IT Product List.

The ONC 2014 Edition criteria support both Stage 1 and 2 Meaningful Use measures required to qualify eligible providers and hospitals for funding under the American Recovery and Reinvestment Act (ARRA).

Visit http://www.iPatientCare.com for more information.