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Implementation of MACRA and the Role of the IRIS Registry

What is “MACRA”?

MACRA

Medicare Access and CHIP Reauthorization Act of 2015

Bipartisan legislation signed into law on April 16, 2015

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- Provides statutory updates of .5% for 5 years
- **Changes the way that Medicare pays clinicians** and establishes a new framework to reward clinicians for **value** over volume
  - **Streamlines** multiple quality reporting programs into 1 new system (MIPS)
  - **Provides bonus payments** for participation in ***eligible*** **alternative payment models (APMs)**

MACRA is part of a broader push towards value and quality

In January 2015, the Department of Health and Human Services announced **new goals** for **value-based payments** and **APMs in Medicare**

Medicare Fee-for-Service

GOAL 1:

30%

Medicare payments are tied to quality or value through **alternative payment models (categories 3-4)** by the end of 2016, and 50% by the end of 2018

GOAL 2:

85%

Medicare fee-for-service payments are **tied to quality or value (categories 2-4)** by the end of 2016, and 90% by the end of 2018

Medicare Reporting Prior to MACRA

Currently there are **multiple quality and value reporting programs** for Medicare clinicians:

Physician Quality Reporting Program (PQRS)

Value-Based Payment Modifier (VM)

Medicare Electronic Health Records (EHR) Incentive Program

Value Based Purchasing

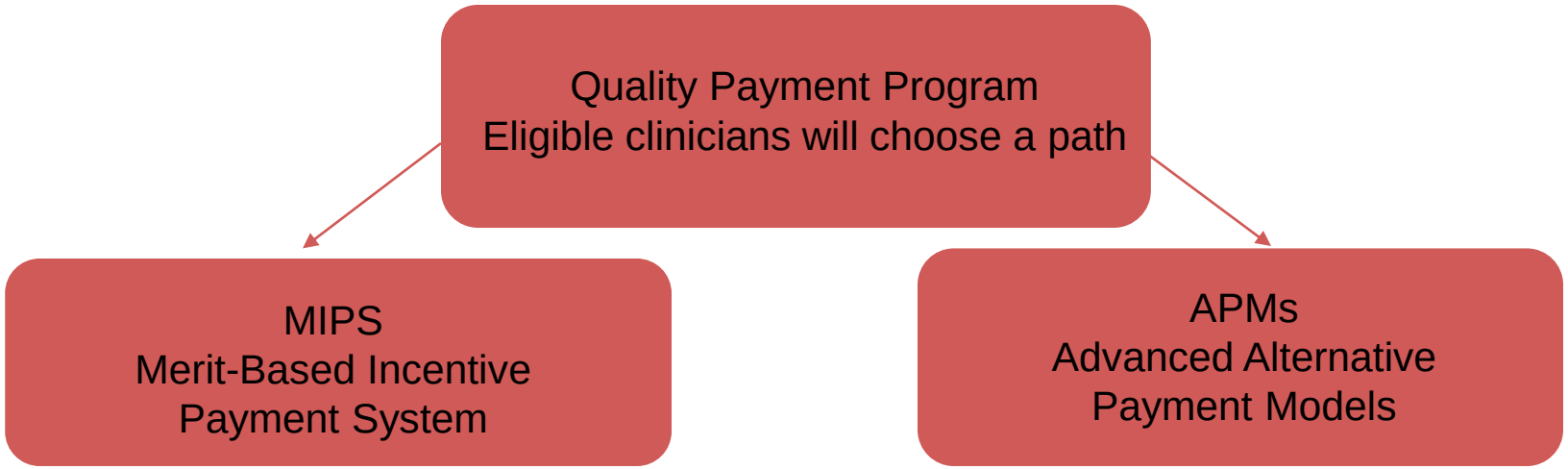
VBP	’09	’10	’11	’12	’13	’14	’15	’16	‘17	‘18
PQRS (Successful Participation)	2	2	1	.5	.5	.5				
(Not Participating)							-1.5	-2	-2	-2
MOC (Participate)	0	0	.5	.5	.5	.5	**CMS may consider MOC in the value based modifier**			
“E”RX (Successful Participation)	2	2	1	1	.5					
(Not Successful)				-1	-1.5	-2				
EHR (Achieve MU)			***Beginning in 2011, physicians can earn up to $44,000 for adoption of EHR/MU (Qualifying for EHR MU precludes e-prescribing bonus)**							
(Not Achieving)							-1	-2	-3	-3 to -5
VBM (based on PQRS participation)							-1 to +2x **(groups of 100+)**	-2 to +2x **(groups of 10 or more)**	-4 to +4x **(groups of 10 or more)** -2 to +2x **(groups of 1 - 9)**	**TBD Potentially** -4 **(or more)**
Total Exposure	4%	4%	2.5% *	+2% to -1% *	+1.5% to -1.5% *	+1% to -2% *	-3.5% to +2x	**Potentially** -6%	**Potentially** -9% **(or more)**	**Potentially** -9 to 11%

MACRA Payment Updates

		2016	2017	2018	2019	2020	2021	2022	2026
Fee Updates		0.5%	0.5%	0.5%	0.5%	0%	0%	0%	0.25 MIPS 0.75% APMs
MIPS (Merit-Based Incentive					↑ 4%	↑ 5%	↑ 7%	↑ 9%	
Payment System)					↓ -4%	↓ -5%	↓ -7%	↓ -9%	
APMs (Alternative payment models)					5%	5%	5%	5%	
								5% bonus stops after 2024	
Additional Funding					**Up to $500 million** authorized every year for MIPS bonuses of up to 10% for exceptional performance (2019-24)				

MACRA

- Beginning in 2017, most physicians will be required to choose whether to be evaluated based on performance measures and activities under the Merit-based Incentive Payment System (MIPS) or to participate in an Advanced Alternative Payment Model (APM)



MIPS

- Merit Based Incentive Payments System
  - Impacts payment January 1, 2019
  - based on 2017 performance
- Consolidates and replaces existing incentive programs (PQRS, MU, VBM)
- Incentives would be based on composite score for each EP
- The vast majority of physicians

MIPS

4 Performance Categories

Quality

Resource use

Clinical practice improvement activities

Advancing Care Information

MU of an EHR

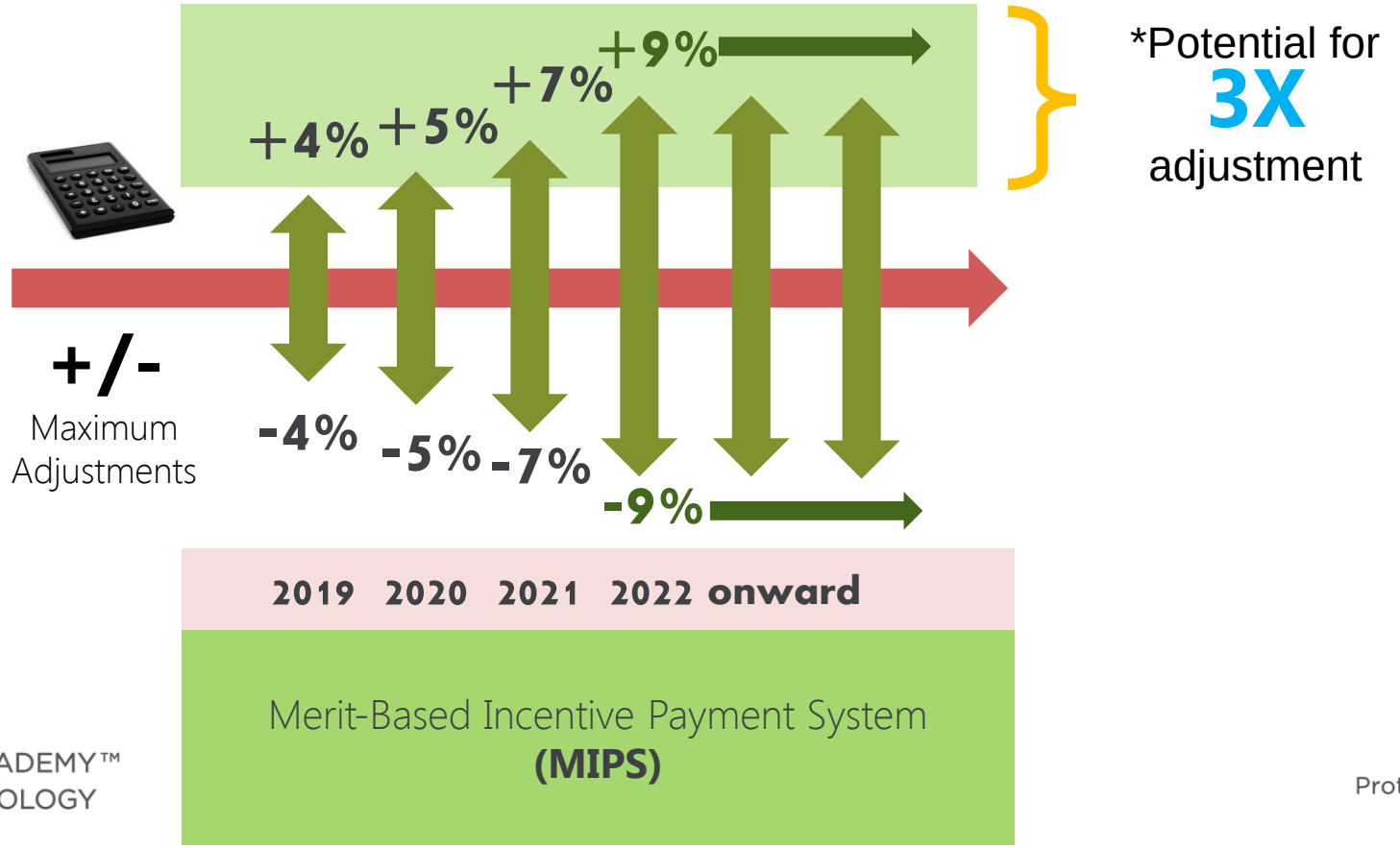
MIPS Composite Performance Score

Initial MIPS Weighting

- Quality measures 30% (50% - 2019, 45% - 2020)
- Resource use 30% (10% - 2019, 15% - 2020)
- Clinical practice 15%
- MU – EHR 25% (15% if 75% qualify)
- Weights change over time
  - When 75% of EPs achieve MU, its weight could be reduced to 15% to emphasize other categories.

How much can MIPS adjust payments?

Note: MIPS will be a **budget-neutral** program. Total upward and downward adjustments will be balanced so that the average change is 0%.



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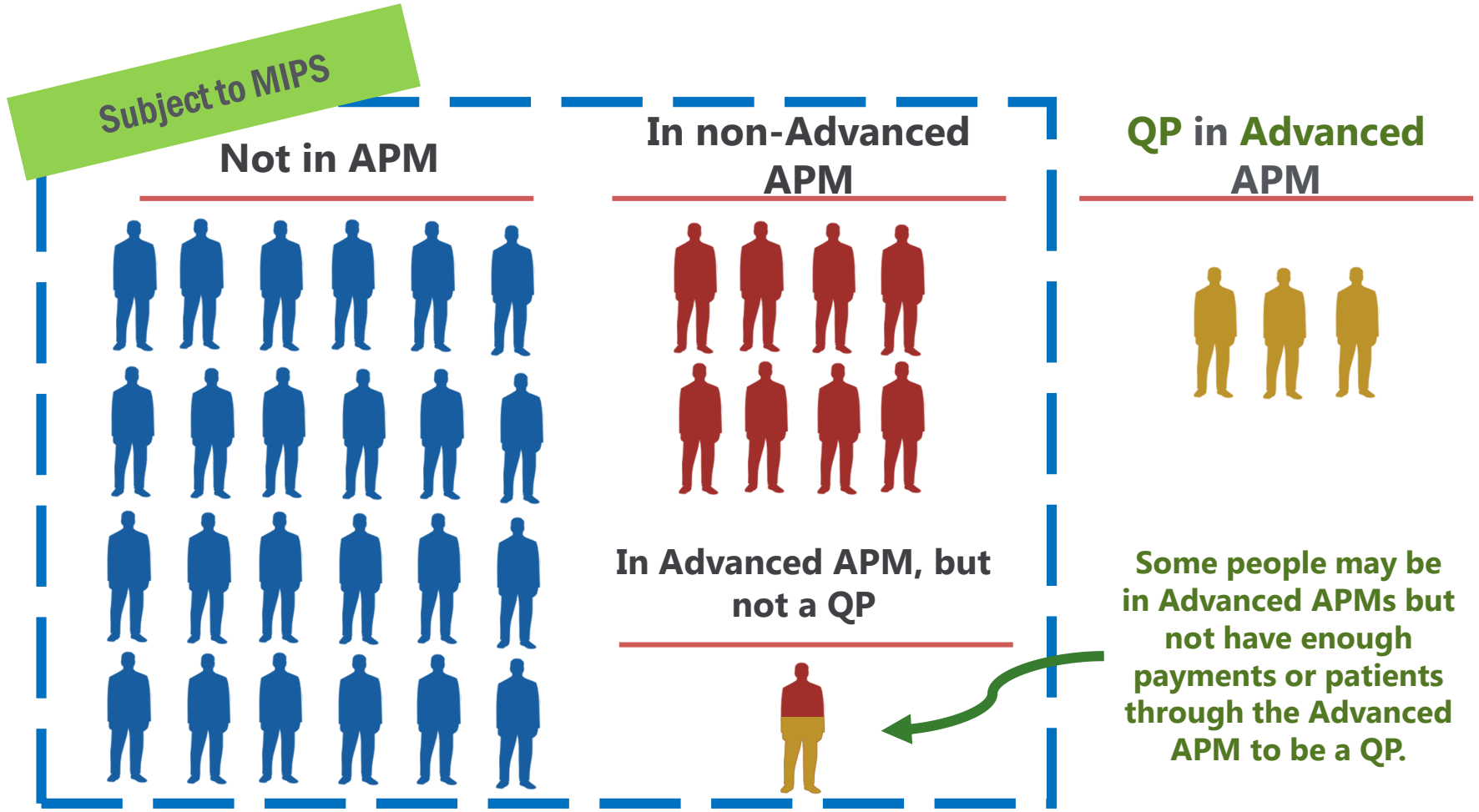
Note: Most clinicians will be subject to MIPS.



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Note: Figure not to scale.

PROPOSED RULE

MIPS: Eligible Clinicians

Eligible Clinicians can participate in MIPS as an:

Individual

Or

Group

A group, as defined by taxpayer identification number (TIN), would be assessed as a group practice across all four MIPS performance categories.

Note: "Virtual groups" will not be implemented in Year 1 of MIPS.

MIPS Exclusions

- See fewer than 100 Medicare patients AND bill less than $10,000 in charges
- Newly enrolled in Medicare during the reporting year
- Advanced APM Participants that meet the required thresholds

MIPS

- “The Secretary shall encourage the use of qualified clinical data registries in carrying out this subsection…”
- IRIS Registry is integral to quality reporting.
- Academy is strongly advocating tighter alignment of IRIS with MIPS.

Quality – 50% of MIPS

- MIPS ECs and groups report 6 quality measures:
  - 1 patient outcomes measure
  - 1 “cross cutting” measure (primary care)
- Reporting mechanisms include:
  - QCDR, Qualified Registry, Certified EHR, Claims based reporting, GPRO Web Interface (groups with >25 ECs)

Quality – 50% of MIPS

- Several changes from the current PQRS:
- Improvements:
  - Lower number of measures required from 9 to 6 to achieve full credit
  - Remove requirement to cover 3 quality domains
  - Partial credit based on number of measures reported
- Issues:
  - Measures groups (including cataracts and diabetic retinopathy) not an option
  - Raising the bar to require reporting on:
    - 80% of eligible Medicare patients for paper claims-based reporters (up from 50%), and
    - 90% of eligible patients from ALL PAYERS for EHR, Qualified Registry and QCDR (up from 50% for QCDR)

Resource Use – 10% of MIPS

- No reporting by the physician required
- ECs measured on:
  - Total Per Capita Cost
  - Medicare Spending Per Beneficiary
  - Same problems as VBM - attribution, no subspecialty recognition, risk adjustment
- New
  - Episode-based Measures: Lens and Cataract Episode

Clinical Practice Improvement Activities – 15% of MIPS

- To earn full credit for CPIA, ECs and groups must report on a sufficient number of activities to reach 60 points
  - Activities are weighted as “medium” 10 pts, or “high” 20 points
- **Exception for small (≤15 ECs)**, rural, and health professional shortage area practices:
  - Only required to report on 2 activities, regardless of weight, to get full credit for CPIA component
- Other exceptions:
  - Certain APM participants (such as Shared Savings ACOs) automatically get 30 out of the 60 points. Medical home participants, earn the full 60 points for CPIA

CPIA – 15% of MIPS

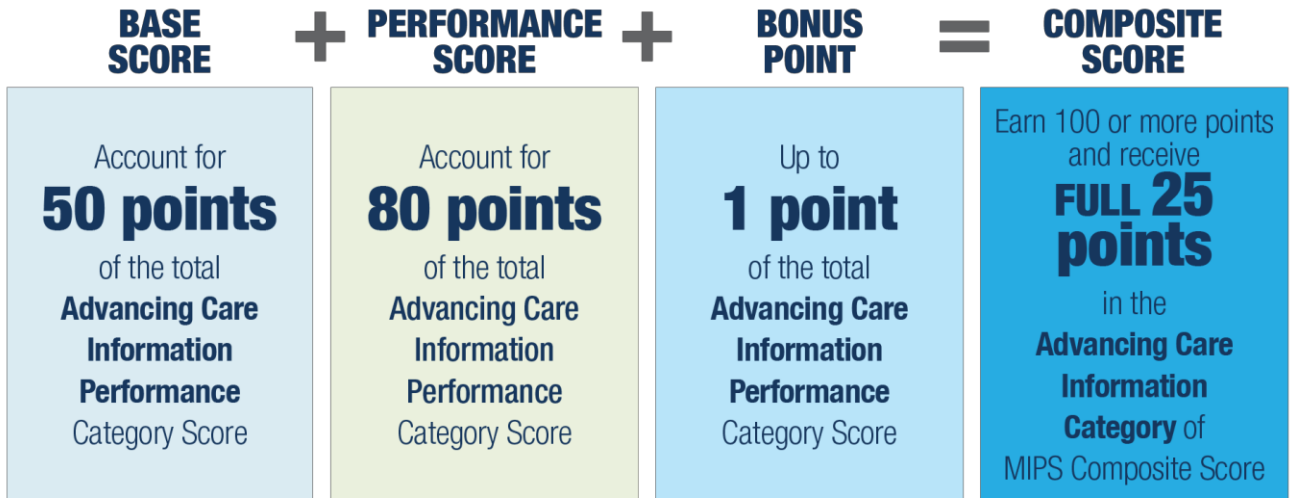
90 proposed activities for providers to choose from, including:

- Participation in a QCDR or clinical data registry run by a medical society (such as IRIS Registry) when the data collected is used for quality improvement.
- Participation in a registry when data is collected for ongoing practice assessment and improvements in patient safety.
- Having expanded evening and weekend hours.
- Provision of same day or next day care when needed for urgent care.
- Using telehealth services.
- Participating in Maintenance of Certification Part IV for improving professional practice.
- Seeing new and follow-up Medicaid patients in a timely manner.

Advancing Care Information/MU
25 % of MIPS

- Proposed Changes:
  - New name for Meaningful Use
  - Removing minimum patient reporting thresholds (for example – use e-prescribing for 50% of patients) - instead, propose to require ECs to report each measure for at least one patient
  - Allow the option for practices to report individually or as a group
  - Remove Clinical Decision Support and Computerized Provider Order Entry requirements in Stage 3 (scribe certification no longer needed)
- Same measures & objectives (Modified Stage 2) in 2017
- All are required to report Stage 3 in 2018

PROPOSED RULE
MIPS: Advancing Care Information Performance Category



The overall Advancing Care Information score would be made up of a base score and a performance score for a maximum score of 100 points

Academy Positions

- Better leverage registries so that participants in IRIS Registry can succeed under all categories in MIPS
- Reinstate quality measures groups for Quality category
- Address attribution, risk adjustment and specialty issues for Resource Use
- All Academy members should have ability to earn maximum number of points
- Scale back and remove problematic and challenging Stage 3 ACI /MU requirements, 90 day reporting

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Alternative Payment Models
APMs

APMs

- Incentive for development and participation in Alternative Payment Models:
  - 5% bonus 2019-2024. 0.75% update after 2025
  - Exemption from MIPS penalties
- Must demonstrate that providers have more than “nominal financial risk” (yet to be defined)
- 25% (2019-20) to 75% (2023) of practice revenues or patient volume must come from APMs (not FFS) to be eligible for bonus

Not All ACOs and APMs are MACRA APMs

Saturday, February 06, 2016

DAILY NEWS

CMS Indicates ACOs Must Accept Penalty Risk To Be Alternative Pay Models

February 04, 2016

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American Academy of Ophthalmology IRIS® Registry

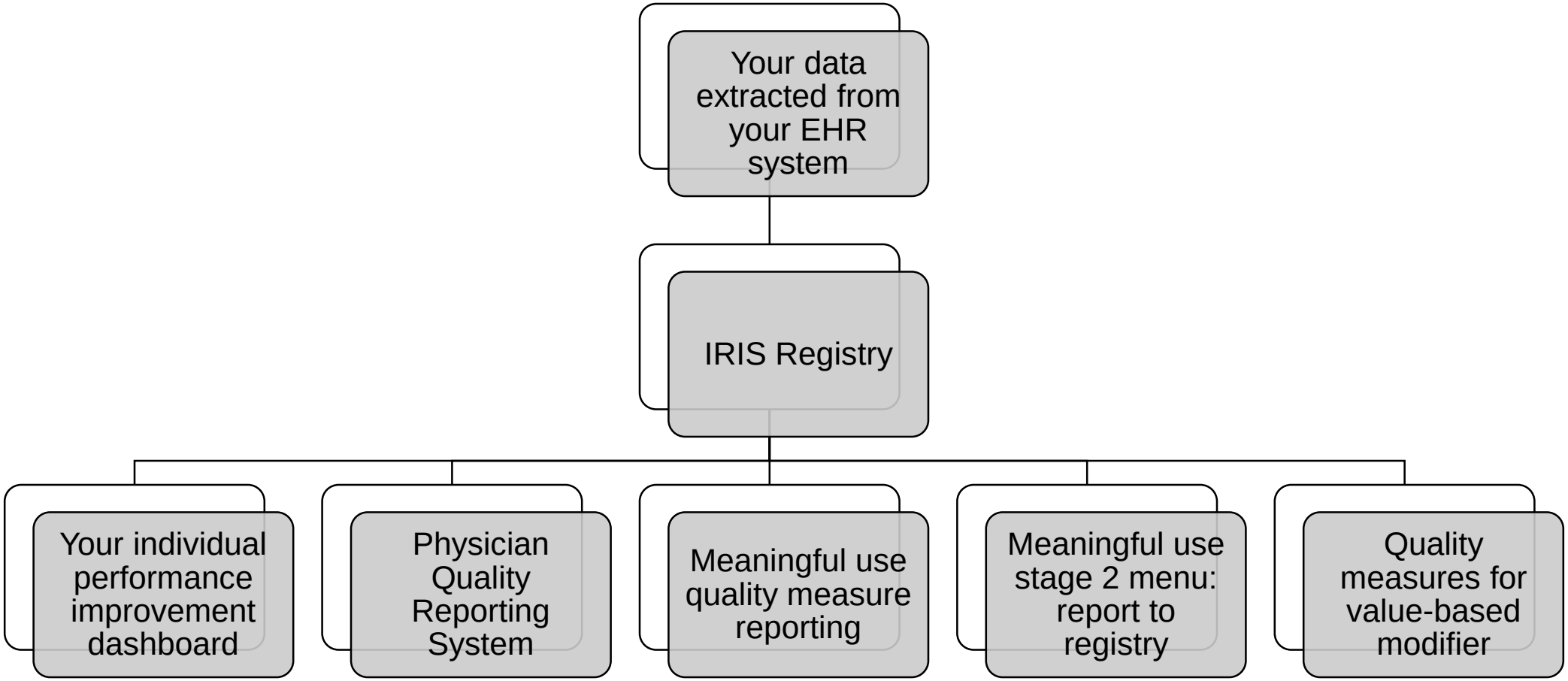
Improving Performance and Outcomes in Ophthalmology

Introduction to IRIS Registry

IRIS Registry (Intelligent Research in Sight) is the nation's first comprehensive eye disease clinical database

- Enables ophthalmologists to use clinical data to improve care delivery and patient outcomes
- Helps practices meet requirements of the federal Physician Quality Reporting System (PQRS)
- Uses HIPAA-compliant methods to collect data from patient records directly from electronic health record (EHR) systems

Value of IRIS Registry



How IRIS Registry Works

Data entry methods

- There are two ways to enter your data
  - EHR integration with automatic uploads
  - Web portal with manual entry
- EHR Integration with automatic uploads
  - FIGMD's System Integration (SI) Solution is designed to integrate with your EHR and enables you to seamlessly participate in the IRIS Registry without any workflow modifications or interference
  - The system integration solution is compatible with nearly any EHR system – all versions, no matter how much customization you've done

How IRIS Registry Works Integrated with 43 EHR Systems

- Amazing Charts
- ChartMaker Medical Suite
- Compulink
- Cybax
- DoctorSoft
- Drchrono
- eClinicalWorks
- EyeDoc EMR
- Eyefinity ExamWRITER
- EyeMD EMR
- GE Centricity EMR
- Greenway Intergy
- Greenway/Primesuite
- HCIT HER
- ifa systems EMR
- iMedicWare
- Integrity EMR for Eyes
- IO Practiceware
- KeyChart EMR
- Lytec
- ManagementPlus
- MaximEyes by First Insight
- Mastermind EHR
- MDIntelleSys
- MDoffice
- MDSuite
- Medent
- MedEvolve
- Medflow
- Medinformatix EHR
- My Vision Express
- NeoMed
- NexTech
- NextGen
- Origin
- Prime Clinical System
- PrognoCIS
- Soapware
- SRS
- TriMed EHR
- VersaSuite
- Vitera EHR
- WebChart by MIE

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IRIS® Registry and MIPS

IRIS Registry is FREE for all Academy members and can help you to meet the requirements of MIPS.

- Quality
  - Like with PQRS, we expect IRIS Registry to continue enable participants to meet their quality reporting requirements, even if you don't have an EHR
  - Participants can track their performance and make improvements to help them achieve optimal performance scores on their quality measures
- CPIA
  - Registry activities proposed for CPIA allow a registry, such as IRIS to fully qualify an EC
  - IRIS Registry may be able to submit your CPIA performance to CMS
- ACI
  - IRIS participants will achieve credit/bonus points for participation in a specialty registry

Current Stats (April 1, 2016)

Contracted

- **13,340** physicians from **4,374** practices

Total for EHR Integration

- **9,533** physicians from **2,251** practices

Number of patient visits

- **82** million, representing **23** million unique patients

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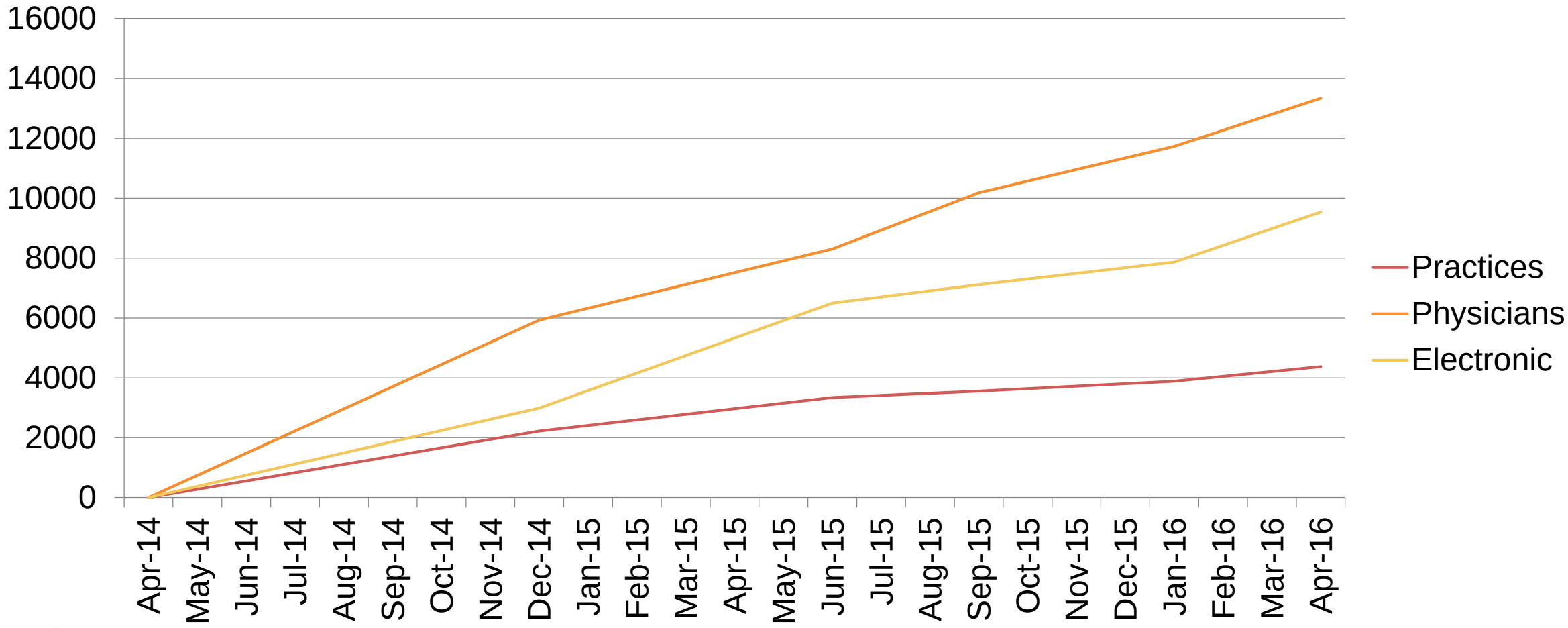
Participation in IRIS Registry



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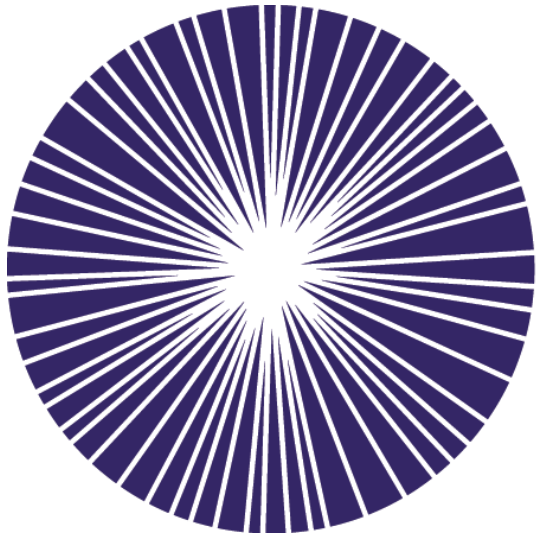
What MDs Are Saying

“The IRIS Registry will represent a seminal change in how the medical specialty of ophthalmology will improve performance and outcomes, while shortening the timeline for the dissemination of important clinical knowledge, research and results of drug and device surveillance.”

David W. Parke II, MD

Academy CEO



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