HEALTH CAPITAL Topics
Volume 9
Issue 5
May 2016
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CMS Issues MACRA Proposed Rule One Year After Passage

On May 9, 2016, the *Centers for Medicare and Medicaid Services* (CMS) issued a proposed rule for implementing changes to the *value-based reimbursement* (VBR) scheme required by the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA).[1] The proposed rule introduces the *Quality Payment Program* (QPP), which implements the *Merit-based Incentive Payment System* (MIPS) and *Alternative Payment Models* (APMs),[2] both of which were first set out in MACRA.[3] Generally, the goal of the QPP is to continue the support of "*…health care quality, efficiency, and patient safety*."[4] To that end, MIPS, which is a consolidation of three payment adjustment programs, aims to increase the utilization of VBR and the flexibility for clinicians by allowing various performance measures to be utilized.[5] Additionally, the aim behind APMs is to incentivize clinicians to take a step further than MIPS in transforming care delivery into a "*…patient-centered health care system that delivers better care, smarter spending, and healthier people and communities*."[6] The effects of this initiative are expected to be widespread, as by 2020, the QPP may affect up to 800,000 clinicians.[7] This *Health Capital Topics* article will briefly discuss the background of MACRA, and detail the requirements and the potential consequences under the proposed regulations regarding MIPS and APMs.

As background, the central goal of MACRA was to replace the *Sustainable Growth Rate* (SGR) Formula.[8] The SGR set annual budget targets for physician services paid under Medicare, which, in practice, led to annual proposals to cut Medicare reimbursement for physician services.[9] Congress continually overruled these cuts, and eventually did away with the SGR altogether by passing MACRA.[10] In addition to replacing the SGR, MACRA also included provisions related to VBR, such as the creation of MIPS and APMs.[11] CMS' proposed rule sets out to implement MACRA's requirements related to MIPS and APMs, through the creation of the QPP.

The first route clinicians may take under the QPP is to participate in MIPS. As noted above, MIPS consolidates three patchwork payment adjustment programs, which are: (1) the *Physician Quality Reporting Program* (PQRS); (2) the *Physician Value-based Modifier* (VM); and, (3) the Medicare *Electronic Health Records* (EHR) program,[12] also known as Meaningful Use.[13] Clinicians receive a single performance score based on four weighted performance categories, which performance score is then used to calculate payment adjustments.[14] A performance period is defined as one calendar year;[15] MIPS begins measuring clinicians on these performance metrics beginning in 2017 (year 1), and providing payment adjustments based on these metrics in 2019.[16] MIPS applies only to *eligible clinicians*, defined as "*…a physician, a physician assistant, nurse practitioner, and clinical nurse specialist, a certified registered nurse anesthetist, and a group that includes such professionals.*"[17] Exempted clinicians include those newly enrolled in Medicare, those who have less than or equal to $10,000 in Medicare charges and less than 101 Medicare patients during the performance year, or those who qualify as an APM participant.[18] In order to increase the flexibility for clinicians in choosing performance measures, MIPS utilizes four performance categories for evaluating a clinician on their provision of high quality and efficient care: quality, resource use, clinical practice improvement activities, and advancement of care information,[19] some of which grant clinicians the option to choose measures most applicable to their practice.[20] First, the quality category makes up 50% of the performance score in year 1 of MIPS, and replaces the PQRS and the quality component of the VM.[21] Clinicians report a minimum of six measures – compared to nine under PQRS – and one additional outcome measure or a high priority measure, such as patient safety, patient experience, and care coordination.[22] In reporting these measures, clinicians have the option to choose from various metrics from the list of PQRS metrics,[23] accommodating varying specialties.[24] Second, the resource use category makes up 10% of the performance score in year 1, and replaces the cost component of the VM. No reporting obligations for clinicians exist for this performance metric, as the clinician's score is based on Medicare claims data,[25] such as per patient total allowed charges for all services, and other measures of utilization of items as services, such as frequency of items and services utilized.[26] The clinician's score in this category is calculated by dividing the total points across all included measures by total points across all possible measures.[27] Third, the clinical practice improvement activities category makes up 15% of the performance score in year 1, and allows clinicians to choose pertinent activities from over 90 options, such as care coordination, patient engagement, and patient safety.[28] Lastly, the advancement of care information category makes up 25% of the performance

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score in year 1, and replaces the Meaningful Use program.[29] Here, a clinician's performance score is based on measures regarding how the clinicians utilize EHRs, focusing on interoperability and information exchange.[30] The four performance categories are combined to calculate clinician's aggregate score, which is compared against a MIPS threshold to determine whether the clinician receives a payment increase, decrease, or no adjustment.[31] MIPS is required to be budget neutral,[32] and payment increases and decreases will therefore be approximately evenly distributed between clinicians below and above the MIPS threshold.[33] For MIPS' first payment year in 2019, the threshold is set at a level where half of the participating clinicians will receive a payment decrease, and the other half will receive a payment increase.[34] CMS set this initial payment threshold by taking data from 2014 and 2015 Medicare Part B allowed charges, PQRS submissions, *Quality and Resource Use Reports* (QRUR) and *Supplemental Quality and Resource Use Reports* (sQRUR) feedback, and Medicare and Medicaid EHR Incentive Program reports.[35] For performance periods in year three (3) and beyond, this threshold will equal the mean or median of all clinicians' performance scores from the previous year.[36] Initially, payment adjustments change annually, and the current maximums in place for decreases are 4% for 2019; 5% for 2020; 7% for 2021; and 9% for 2022 and beyond.[37] Payment increases may, but generally will not, go beyond each year's maximum.[38]

As an alternative to participating in MIPS, clinicians may opt to participate in APMs.[39] Under MACRA, an APM is defined as "*(i) A model under section 1115A* [of the Social Security Act (the Act)], *(ii) The shared savings program under section 1899* [of the Act], *(iii) A demonstration under section 1866C* [of the Act], *and (iv) A demonstration required by Federal law.*"[40] Three requirements must be met for a clinician to earn incentive payments for participation in an APM under the QPP: (1) use of certified EHR technology, (2) use of quality measures similar to those under MIPS in provider reimbursement, and (3) exist as either a Medical Home Model under the Act, or bear more than a nominal amount of risk for monetary losses.[41] For years 2019-2024, clinicians who meet the requirements for APM participation are excluded from MIPS, and therefore aren't required to report MIPS performance metrics.[42] Additionally, clinicians who qualify as APM participants will receive a 5% Medicare Part B incentive payment.[43] Beginning in 2026, qualifying clinicians utilizing the APM model will receive a higher increase under the *physician fee schedule* (PFS) than those clinicians who do not.[44] Based on definition of an APM, CMS included in the proposed rule a list of models that would qualify as APMs, including: (1) Medicare Shared Savings Program – Tracks 2 and 3; (2) Next Generation *Accountable Care Organization* (ACO) Model; and, (3) the Comprehensive Primary Care Plus model.[45] Under the proposed rule, CMS will update this list at least annually, as new APMs are established.[46] Once a proper model is utilized, clinicians must then participate in that model to a sufficient extent during the performance year in order to receive incentive payments for APMs.[47] Currently, in order to qualify as an APM participant, clinicians must receive a minimum amount of their payments through an APM, which thresholds are set at: 25% for 2019-2020; 50% for 2021-2022; and 75% for 2023 and beyond.[48] Alternatively, in order to qualify as an APM participant, clinicians may meet thresholds related to the share of patients that they treat through APMs, which are set at: 20% for 2019-2020; 35% for 2021-2022; and 50% for 2023 and beyond.[49] From 2019 to 2020, this participation requirement may only be satisfied through Medicare charges or patients; however, beginning in 2021, the participation requirement may include non-Medicare charges or patients.[50]

With the ever-changing healthcare field seemingly in a constant state of flux, the QPP represents the next link in a long chain of reforms and new reimbursement programs.[51] This initiative by CMS has the potential for large impact on physician practices, in light of both the shifting regulatory obligations for clinicians, as well as potential consequences flowing from those obligations. CMS estimates that, in 2019, up to 746,000 clinicians will receive payment adjustments under MIPS, and that $500 million in exceptional performance payments will be made.[52] Additionally, up to an estimated 90,000 clinicians will qualify for sufficient participation in APMs, resulting in up to $429 million in incentive payments.[53] Clinicians should be cognizant of how this proposed rule could affect their practices, and be prepared to abide by the altered regulations brought forth by the QPP.

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15 Federal Register, Vol. 81, No. 89 (May 9, 2016) p. 28163.
16 *Ibid*.; CMS, Medicare Access and CHIP Reauthorization Act of 2015: Quality Payment Program, p. 6.
17 Federal Register, Vol. 81, No. 89 (May 9, 2016) p. 28173.
18 *Ibid*, p. 28177-8; CMS, Medicare Access and CHIP Reauthorization Act of 2015: Quality Payment Program, p. 6.
19 Federal Register, Vol. 81, No. 89 (May 9, 2016) p. 28163.
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22 Federal Register, Vol. 81, No. 89 (May 9, 2016) p. 28164.
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25 *Ibid*.
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30 *Ibid*.
31 Federal Register, Vol. 81, No. 89 (May 9, 2016) p. 28164.
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33 *Ibid*, p. 28165, 28273.
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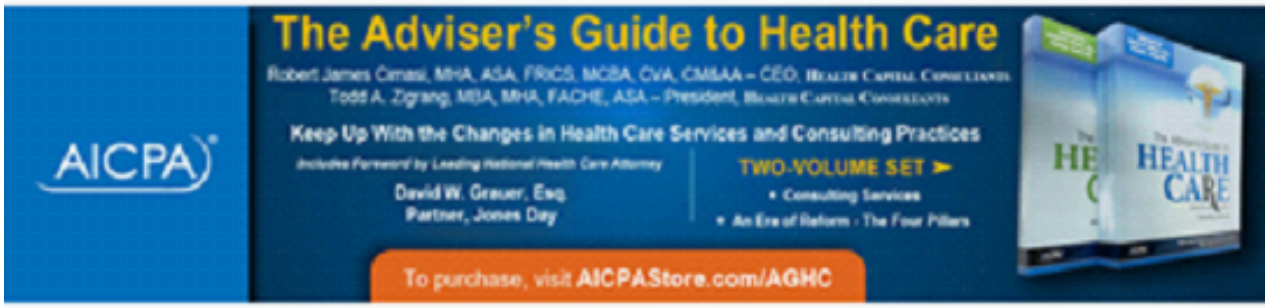

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