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LATE FALL 2016 NEWSLETTER

Changes in Medicare are in the air! On October 14, 2016, the Department of Health and Human Services issued the Final Rule regarding implementation of key provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA is the legislation that replaced the flawed sustainable Growth Rate formula and that accelerates the conversion of Part B clinician payments from a fee-for-service to a value-based payment system. In this article we explain the new approach to paying clinicians for the value and quality of care they provide.

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MEDICARE CHANGES – WHAT LIES AHEAD?

The Quality Payment Program (QPP) described in the Final Rule offers two paths. The first, the Merit-based Incentive Payment System (MIPS), is the one in which most Medicare providers who meet eligibility criteria will initially participate. It offers a small annual inflationary performance-based adjustment to the Part B fee schedule. The second is the Advanced Alternative Payment Models (APMs). It offers payment adjustments as well as an incentive payment for participating in the APM.

Merit-based Incentive Payment System (MIPS)

Under the current fee-for-service program, Medicare recognizes and measures the value and quality of care by physician and other providers through multiple programs. Examples are the Physician Quality Reporting System (PQRS), the Value Modifier Program, and the Medical Health Record (EHR) Incentive Program (i.e. Meaningful Use). Recognizing that the current quality programs are both confusing and time-consuming for providers, Congress created a single program, the Merit-based Incentive Payment System (MIPS). MIPS not only consolidates a variety of programs but also offers Medicare providers the flexibility to choose quality measures and activities that are most appropriate to the type of care they provide.

MIPS creates four performance categories, each of which contributes to the total amount of Medicare reimbursement. In most cases, eligible clinicians can choose to participate as individuals or as a group with a single tax ID number. The four performance categories are:

1. **Cost/Resource Use:** 0 percent of the total score in year 1 and a replacement of the Value Modifier Program (i.e. Resource Use). The score is based on Medicare claims submission and does not require special reporting. The category uses more than 40 episode-specific measures to account for differences among specialties.

As performance feedback becomes available from claims analysis, this category's contribution to the overall performance score will increase to 30 percent by 2021.

2. **Quality:** 60 percent of the total score in year 1 and a replacement for PQRS and the quality component of the Value Modifier Program. To qualify for the performance award, eligible clinicians choose and report on six quality measures or one specialty-specific or subspecialty-specific measure set. In 2017, there is an option to reduce and simplify the reporting to one quality measure or one improvement activity.

3. **Clinical Practice Improvement Activities:** 15 percent of the total score in year 1. Eligible clinicians are rewarded for clinical practice improvement activities such as those focused on care coordination, engagement of Medicare beneficiaries, and patient safety. They can choose from more than 90 options and also receive credit in this category from participation in Alternative Payment Models and in Patient-Centered Medical Homes. Eligible clinicians may attest to having completed up to four medium-weighted or two high-weighted clinical practice improvement activities. There are special provisions for transition year 2017.

4. **Advancing Care Information:** 25 percent of the total score in year 1 and a replacement for the Medicare EHR Incentive Program (i.e. Meaningful Use). Clinicians choose to report customizable measures that show how they use EHR technology in their daily operations, with a particular emphasis on interoperability and information exchange. In contrast to the current Meaningful Use program, this last category does not require all-or-nothing measurement or quarterly reporting.

The relative weighting of the four categories will change in subsequent years. Moreover, in certain circumstances where a clinician's performance is undeterminable in a particular category, MIPS sets the weight of that category to 0 percent and redistributes the weight among the other categories.

By law MIPS is budget neutral. Therefore, each clinician's MIPS score is used to compute a positive, negative, or neutral adjustment to Medicare payments. In year 1, depending on the variation in MIPS scores, both positive and negative adjustments will be calculated so that each is no more than 4 percent. The highest performers will receive additional bonuses.

Advanced Alternative Payment Models (APMs)

Although most eligible clinicians would start with the MIPS option, those who take a further step toward care transformation by participating to a sufficient extent in Advanced Alternative Payment Models are exempt from the MIPS payment adjustment and can qualify for a 5 percent Medicare Part B incentive payment.

In order to qualify for APM incentive payments, a clinician must meet participation requirements that are spelled out in the statute and that increase over time. At the outset, the participation criteria include only Medicare programs. By 2019, clinicians can qualify for incentive payments based in part on participation in Advanced APMs developed by private and public non-Medicare providers.

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What types of arrangements qualify as APMs? Examples are the CMS Innovation Center models, Shared Savings Program tracks, or statutorily required demonstration programs in which clinicians accept both risk and reward for providing coordinated, high-quality, and efficient care. These models must also meet criteria for payment based on quality measurement and EHR use.

The types of programs that currently qualify as APMs are: comprehensive end-stage renal disease care models, comprehensive primary care plus (CPC+), Medicare shared savings program (Tracks 2 and 3), next generation ACO model, and oncology care model two-sided risk arrangement (available in 2016). Primary care physicians can also participate through medical home models. CMS expects to update the list on an ongoing basis.

Who Is Eligible to Participate in the Quality Payment Program And What's The Timetable?

Let's talk about eligibility for participation and timing. Some of the modifications made by CMS in response to comments about the Proposed Rule changed the criteria for participation. If you bill Medicare more than $30,000 per year or provide care for more than 100 Medicare patients per year and are a physician, physician assistant, nurse practitioner, clinical nurse specialist, or certified registered nurse anesthetist, you are automatically a participant when the program begins on January 1, 2017. There's one exception – if 2017 is your first year of participation in Medicare, you cannot be in the MIPS track. In 2019, additional healthcare professionals become eligible to participate: physical and occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, psychologists, and dietitians/nutritional professionals.

With respect to timing, there are four steps: collection of information on quality, submission, receipt of feedback, and payment adjustment. If you meet the criteria identified above for starting in 2017 and choose the MIPS option, you can begin collecting performance data as early as January 1, 2017. You have the option of moving at a slower pace and starting later in 2017, provided you begin between January 1 and October 2, 2017. Regardless of when you start the data collection process, you must submit performance data by March 31, 2018. Feedback will be available prior to the first payment adjustments on January 1, 2019. If you choose the APM option, the Advanced APM in which you participate will submit the data on your behalf. The timetable is the same.

How Will the Quality Payment Program Change Medicare Payments?

Changes in your Medicare payments for eligible clinicians will depend on the option that you choose (MIPS or APM), the time period for which you submit, and on the quality results. If you choose the MIPS option, your payment may be adjusted up, down, or not at all. If you are eligible but don't submit any 2017 data, you'll receive a 4 percent negative payment adjustment. If you submit a minimum of 2017 data (e.g. one quality measure or one improvement activity), your payment may not change at all. If you submit data for at least 90 days of 2017, your payment may remain the same or increase slightly. If you submit for the full year 2017 you may earn a moderate positive payment adjustment. With respect to the APM option, if you receive 25 percent of Medicare covered professional services or see 20 percent of your Medicare patients through an Advanced APM in 2017, you will earn a 5 percent incentive payment in 2019.

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What's Next?

Stay tuned. CMS has already published a great deal of information on its website (**www.cms.gov**) and there will be more to come.

Need Help with MACRA or Other Reimbursement Issues?

Don't wait until next year to begin your impact assessment of this new ruling on your practice. Perhaps it's also a good time to assess practice reimbursement on a broader scale. Satinsky Consulting, LLC specializes in medical practice management and is adept at helping practices sort through both public and private reimbursement challenges to help improve the practice's bottom line. For additional information on MACRA and other reimbursement concerns, contact Margie Satinsky, MBA, President of Satinsky Consulting, LLC. She's the author of numerous books and articles, including *Medical Practice Management in the 21st Century*. You can contact Margie at **margie@satinskyconsulting.com** or 919.383.5998. Or check the website (**www.satinskyconsulting.com**).

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