

MACRA: Medicare and CHIP Reauthorization Act

New Models for Physician Payments: What Suppliers Need to Know – September 2017

KEY DEADLINE APPROACHING

If your physician customers plan to participate in a full 90-day continuous reporting period and be eligible for the partial participation track, the last day to begin reporting is **October 2, 2017**. While some reporting vendors may be able to collect reporting data retroactively, this will not be true for all vendors or for all submission methods. Understanding your options before this upcoming deadline will help clinicians avoid a negative penalty.

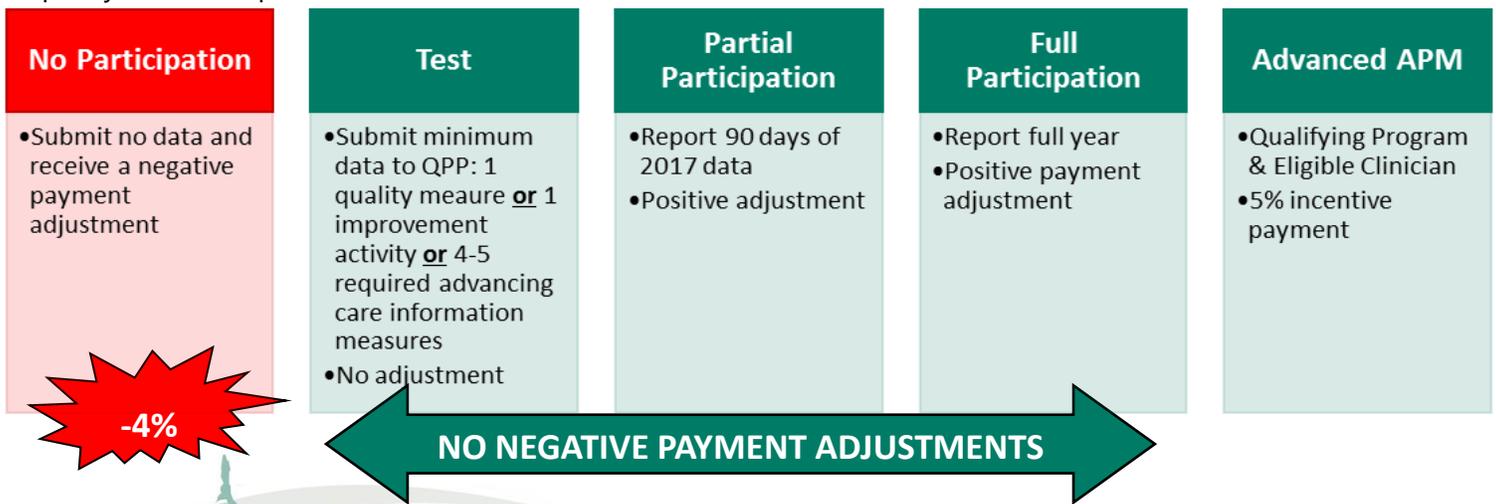
MACRA was passed by Congress to provide stability for physician payments year to year. Additionally, physicians must now choose to participate between the two options under the Quality Payment Program (QPP) which was created by MACRA: the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). This decision impacts how physicians will be reimbursed beginning in 2019. The MIPS track streamlines CMS' current quality program, while APMs go a step further by offering an additional financial incentive to physicians willing to take on higher financial risk and meet higher quality standards.

Key Takeaways:

- Two Options: MIPS & APM Payment Models
- The majority of physicians are expected to stay in MIPS
- Reporting data will affect payments 2 years later (For example: 2017 reporting will be used to determine 2019 payments)
- MACRA does **not** replace fee-for-service or the Physician Fee Schedule, but instead

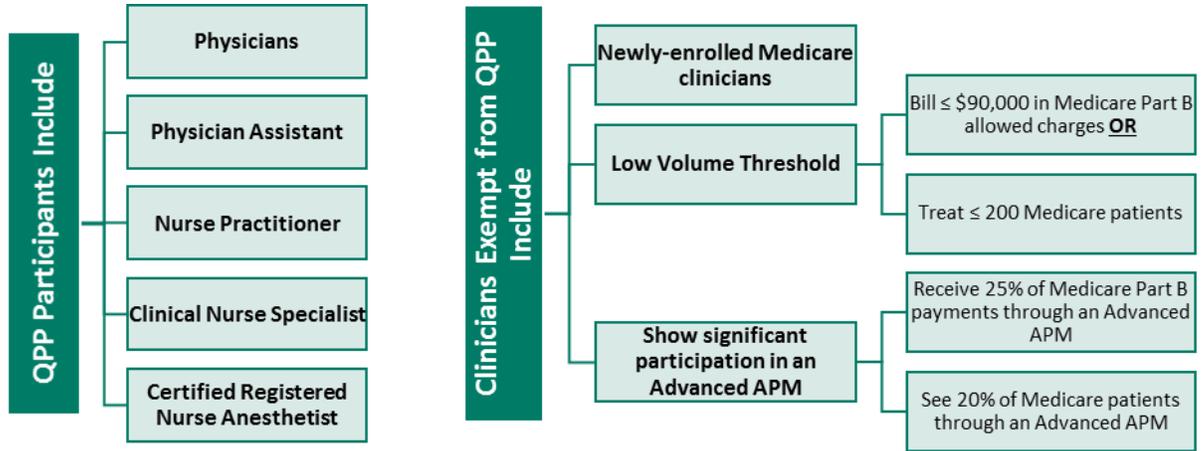
Clinicians Afforded Flexibility During Implementation

In 2017, the Trump Administration has continued the implementation of MACRA, and done so pursuing a strategy of slow implementation in an effort to ease the reporting requirements, especially for clinicians in small independent and rural practices. This is best illustrated through the Pick Your Pace program, which offers clinicians the option to choose one of four tracks that will yield no negative payment adjustments. While clinicians can still be eligible for a full positive payment adjustment by participating in the "partial participation" track, full participation will yield the best opportunity to receive the maximum positive payment adjustment as it provides the most measures to pick from and submit, more reliable data submissions, and the ability to qualify for bonus points.



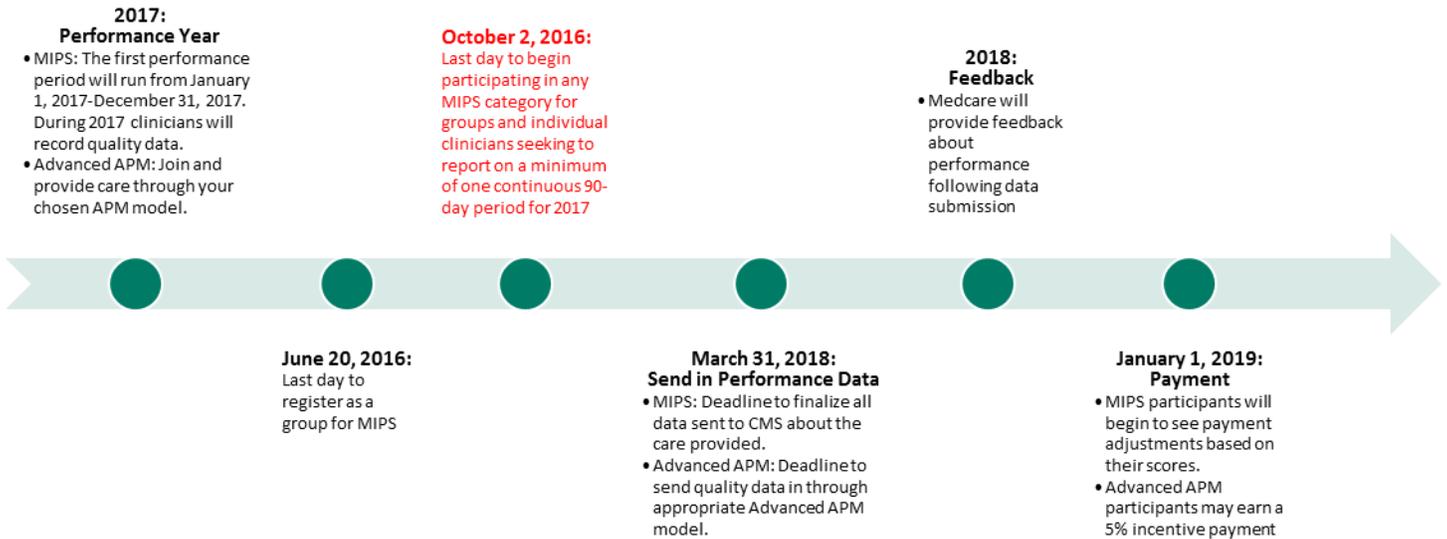
Participation

Any clinician who does not fall under one of the three exemptions (listed below) must participate in the QPP to avoid a negative payment adjustment. Most clinicians (expected to include over 566,000) will participate in MIPS. Exempted practitioners can choose to report into MIPS to prepare for future years when they may be eligible, but they will not receive a payment adjustment. Clinicians can check their status at qpp.cms.gov.



MACRA Timeline

While reporting under the QPP begins in 2017, payments based on the data collected will not begin until 2019. After clinicians finish submitting data for their 2017 performance on or before March 31, 2018, they should already be looking to collect 2018 data for 2020 payments. Considering the quick turnaround, CMS will provide feedback based on performance during the 2018 performance year to give clinicians the opportunity to improve their scores for payment year 2020.

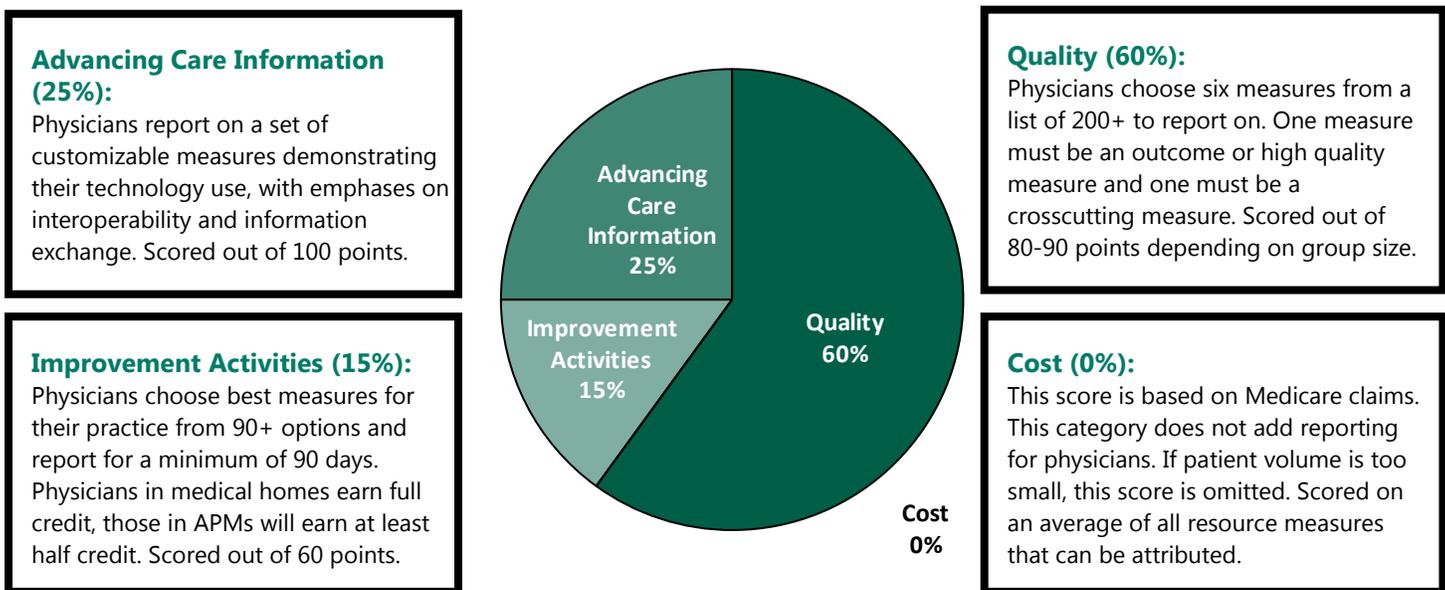


Merit-Based Incentive Payment System (MIPS)

MIPS has consolidated and replaced all of the former Medicare fee-for-service payment quality programs with one value-based performance program. The current programs: Electronic Health Records (EHR) incentive payment program, the Physician Quality Reporting System (PQRS) and the Value-Based Payment Modifier (VBPM) will all sunset (expire) at the end of CY 2018. Physicians would be able to cherry pick measures under the four domains in order to account for diversity between specialties.

Four basic quality domains will be used to develop a physician's final MIPS score. The four domains to be considered are: **Quality, Advancing Care Information, Improvement Activities, and Cost**. There is no upward limit on how many measures clinicians can choose to report on. If a clinician reports more than the required measures CMS will use the top scores to determine the overall MIPS score. For the first round of MIPS reporting, the cost category is set to be weighted at 0%. Ultimately the cost score is set to be weighted at 30% with quality to be reduced to 30% to account for the change.

MIPS Performance Categories



Penalties

The resulting MIPS score is used to determine how much the provider will be paid in comparison to other MIPS providers. Reimbursements are adjusted into a single, budget-neutral payment. Because the program is budget neutral, the overall negative and positive adjustments will balance. By the year 2022, the range could reach -9% to +27%. The law allows for an additional \$500 million in bonuses to reward exceptional performance, which are exempt from the budget neutrality requirement. This will allow exceptional performers a gradually increasing adjustment based on their MIPS score of up to an additional 10%.

	Baseline Payment Adjustment	Maximum Positive Payment Adjustment
2019	-/+ 4%	+ 12%
2020	-/+ 5%	+ 15%
2021	-/+ 7%	+ 21%
2022	-/+ 9%	+ 27%

MIPS Submission Options

As clinicians consider which measures to report on, there are several things to keep in mind. The first consideration is whether to report as an individual or a group. While the deadline to register as a group has passed for 2017, it may be worth considering for future reporting years. Next, although there is flexibility to pick a separate submission method for each performance category, only one submission method may be used per category. For example, if you choose to report quality measures through EHR submission methods, all six measures must be reported on through EHR submission, but you may opt to submit improvement activities through a qualified registry.

It is also worth noting that some submission methods upload and report data to CMS right away without the opportunity to correct data errors, while other methods may need to be submitted during the reporting period which takes place from January through March of 2018.

Finally, all submission methods may not be available for all measures. Clinicians should ensure that whichever method they choose to use for reporting, that method is available for the measures that they would like to report on. Whichever method is selected, it is important to contact a preferred vendor or registry directly to verify reporting deadlines and confirm that the data will be reported to CMS.

Submission Mechanism	How does it work?
Qualified Clinical Data Registry (QCDR)	A QCDR is a CMS-approved entity 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. Each QCDR typically provides tailored instructions on data submission for eligible clinicians.
Qualified Registry	A Qualified Registry collects clinical data from an eligible clinician or group of eligible clinicians and submits it to CMS on their behalf.
Electronic Health Record (EHR)	Eligible clinicians submit data directly through the use of an HER system that is considered certified EHR technology (CEHRT). Alternatively clinicians may work with a qualified EHR data submission vendor (DSV) who submits on behalf of the clinician or group.
Attestation	Eligible clinicians prove (attest) that they have completed measures or activities.
CMS Web Interface (groups only)	A secure internet-based application available to pre-registered groups of clinicians. CMS loads the Web Interface with the group's patients. The group then completes data for the pre-populated patients. This was formerly known as the Group Practice Reporting Option (GPRO)
Claims	Clinicians select measures and begin reporting through the routine billing process.

Advanced Alternative Payment Models (APMs)

APMs offer an incentive for physicians to completely opt out of traditional Medicare fee-for-service payments. Opting into an APM requires accepting financial risk for providing coordinated, high-quality care. Physicians who significantly participate in Advanced APMs are excluded from MIPS adjustments, and instead qualify for a 5% per year Medicare Part B incentive payment between the years 2019 and 2024.

Beginning in 2026, APM physicians would receive a higher fee schedule update than non-APM physicians. CMS established 3 standards – financial risk, quality measures and certified EHR technology – to qualify as an APM.

Financial Risk	<ul style="list-style-type: none"> • Total risk: must be at least 4% of the APM spending target • Marginal risk: must be at least 30% • Minimum loss rate: no greater than 4%
Quality Measures	<ul style="list-style-type: none"> • Evidence-based • Reliable • Valid • At least one must be an outcome measure if applicable
Certified EHR Technology	<ul style="list-style-type: none"> • At least 50% of clinicians use EHR technology • Increases to 75% in the second performance year

Qualifying APMs

CMS identified seven APM models for performance year 2017. While this is the list for the current performance year, CMS is expected to encourage greater participation through the Advanced APM track. Thus as MACRA continues to be implemented there will likely be models added to the Advanced APM track along with greater participation. This list would be updated annually.



For clinicians who are concerned about meeting the requirements for “significant participation” which include receiving 25% of Medicare Part B payments or 20% of Medicare patients through the Advanced APM model, they may choose to also report into MIPS to avoid a negative adjustment. Clinicians participating in APMs that do not qualify as “Advanced” will receive MIPS adjustments in addition to their APM-specific rewards.

Additional Resources:

- CMS Quality Payment Program Homepage: www.qpp.cms.gov
- [Final Rule for 2017 Performance Period](#)
- [Full Text of MACRA](#)
- [CMS Webinars on the Quality Payment Program](#)