Reinhart

Medicare Access and CHIP Reauthorization Act of 2015

POSTED:

Jul 27, 2016

RELATED PRACTICES:

Health Care

https://www.reinhartlaw.com/practices/health-care

President Obama signed into law the Medicare Access and CHIP Reauthorization Act ("MACRA") on April 16, 2015. One year later, on April 27, 2016, the Department of Health and Human Services ("DHHS") released a 962 page proposed rule to begin implementing MACRA.

MACRA, also known as the "doc fix," repeals the outdated sustainable growth rate ("SGR") formula for calculating Medicare payment rates to physicians. MACRA replaces the SGR with a new payment update system, and creates two performance based payment adjustment pathways—alternative payment models ("APMs") and the merit based incentive payment system ("MIPS").

Background

Under Medicare, physician payment rates are based on the Medicare Physician Fee Schedule ("MPFS"). The MPFS assigns values to over 7,500 service codes that cover physician work, practice expenses and malpractice fees. The MPFS is subject to annual updates.

1. The SGR. Before MACRA, MPFS's annual updates were governed by the SGR formula. The SGR was enacted through the Balanced Budget Act of 1997 as a Medicare cost control system. The SGR formula created a "target expenditures" number calculated from the number of fee for service beneficiaries and the estimated growth in the ten year average annual percentage change in the gross domestic product. If actual physician expenditures exceeded target expenditures, physician payment rates were decreased; if physician expenditures fell below the target, physician payment rates were increased.
   In 2002, for the first time, physician expenditures exceeded target expenditures. Therefore, the SGR formula mandated a 4.8% MPFS reduction. Since 2002, physician expenditures have consistently exceeded target expenditures. But, instead of implementing the SGR mandated payment cuts, Congress enacted a series of 17 laws ("doc fixes") to override reductions in physician payment rates. Without these short term fixes, physician payment rates were to be reduced by 21% beginning on April 1, 2015.

2. Pre MACRA Payment Modifiers. Currently, physician payments are also modified by three separate quality measures—the physician quality reporting system ("PQRS"), the meaningful use of electronic health record technology ("MU") and the value based payment modifier ("VM").

- PQRS—The PQRS incentive program increases payment to physicians who report data on various quality measures.
- MU—The MU incentive program increases payment to physicians who meaningfully use certified electronic health record ("EHR") technology to improve the quality and coordination of care.
- VM—The VM incentive program increases payment to physicians who provide quality care at a low cost.

Under MACRA, each of these measures will remain in effect until December 31, 2018. Reporting periods for the measures end in 2016. Beginning on January 1, 2019, the measures will be replaced by a new payment adjustment system.

MACRA's Physician Payment Provisions

MACRA, which consists of 62 provisions, will be incrementally phased in by 2026. Title I of the statute modernizes the Medicare physician payment system in two primary ways. First, MACRA repeals the SGR and replaces it with a new payment update system. Second, MACRA creates two performance based pathways in which physicians will earn additional payment adjustments.

MACRA's provisions will apply only to "clinicians." MACRA defines a "clinician" as a physician, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse anesthetist or any group that includes these professionals. In future years, the definition of "clinician" will be expanded to apply to additional professionals.

1. The New Payment Update System. MACRA replaces the SGR's fluctuating payment update system with a schedule of fixed payment updates. Beginning in January 2016, all Medicare clinicians will receive the following payment updates:

- January 1, 2016—December 31, 2016: 5%

- January 1, 2017—December 31, 2017: 5%
- January 1, 2018—December 31, 2018: 5%
- January 1, 2019—December 31, 2019: 5%
- January 1, 2020—December 31, 2020: 0%
- January 1, 2021—December 31, 2021: 0%
- January 1, 2022—December 31, 2022: 0%
- January 1, 2023—December 31, 2023: 0%
- January 1, 2024—December 31, 2024: 0%
- January 1, 2025—December 31, 2025: 0%

In January 2026, the payment update system will diverge into two separate payment update systems—one for qualifying APM participants, and one for MIPS and partial qualifying APM participants. Qualifying APM participants will receive an annual 0.75% payment update from 2026 onward; MIPS and partial qualifying APM participants will receive an annual 0.25% payment update from 2026 onward.

The Performance Based Pathways. Beginning in 2019, clinicians will receive an additional payment adjustment from one of two possible pathways: advanced APMs and MIPS. A clinician must participate in either an advanced APM or MIPS, but not both.

(a) Advanced APMs. One pathway to payment adjustments is participation in an advanced APM. The APM pathway is more difficult than the MIPS pathway because of the rigorous requirements involved. However, clinicians who choose the advanced APM pathway will receive more incentives than those who choose MIPS.

An advanced APM is a payment model that requires a clinician to accept risk for providing coordinated, high quality care. A payment model must meet three criteria to qualify as an advanced APM. It must:

- assume meaningful financial risk (or be a medical home model under Center for Medicare and Medicaid Innovation ("CMMI") authority);

- use EHR technology; and
- use quality measures comparable to those used by MIPS.

Existing advanced APMs include the Comprehensive ESRD Care Model, Comprehensive Primary Care Plus, Medicare Shared Savings Program, Next Generation ACO Model, Patient Centered Medical Homes, and Oncology Care Model Two Sided Risk Arrangement. While few APMs exist, MACRA established the Physician Focused Payment Models Technical Advisory Committee to aid in the development of new APMs so that clinicians will have more opportunities to participate.

However, it is not enough for a clinician to simply participate in an advanced APM to receive incentives through the APM pathway. Instead, a clinician must be a qualifying APM participant or a partial qualifying APM participant.

(i) Qualifying APM Participants. To receive maximum incentives through advanced APM participation, a clinician must be a qualifying participant ("QP"). A clinician is a QP if the clinician receives a certain threshold of Medicare payments or patients through an APM during a given year. Over time, the threshold will increase, making it more difficult for clinicians to become QPs.

In the given year, a clinician must receive the following minimum percentage of either payments or patients through an advanced APM entity:

- Payments:
- 2019—25%
- 2020—25%
- 2021—50%
- 2022—50%
- 2023 and later—75%
- Patients:
- 2019—20%
- 2020—20%

- 2021—35%
- 2022—35%
- 2023 and later—50%

Under MACRA, if a clinician meets the requirements to be a QP, the clinician will receive three incentives. First, between 2019 and 2024, QPs will receive annual 5% payment bonuses. Second, beginning in January 2026, QPs will receive 0.75% annual payment updates. Lastly, QPs will be exempt from MIPS.

(ii) Partial Qualifying APM Participants. A partial qualifying APM participant is a clinician who receives Medicare payments through an advanced APM but does not meet the minimum payment or patient thresholds. A partial qualifying APM will not receive the 5% bonuses or the 0.75% payment updates. However, a partial qualifying APM may opt out of MIPS participation.

(b) MIPS. MIPS is the second pathway to annual payment adjustments. In 2019, MIPS will replace the PQRS, MU and VM programs with a single payment adjustment system. Unlike the APM pathway, MIPS adjustments are not fixed and are not automatic. Clinicians will earn payment increases (or decreases) through performance.

(i) MIPS Eligible Clinicians. MIPS will apply to any MIPS eligible clinician ("MEC"). An MEC is any physician, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse anesthetist or a group of these individuals. Most individual MECs will elect to participate in MIPS as a group MEC. However, clinicians may participate in MIPS as individuals.

Some otherwise eligible clinicians will be exempt from MIPS. They include:

- Qualifying or partial qualifying APM participants
- Clinicians who are new to Medicare
- Low volume practitioners (practitioners with less than $10,000 in Medicare claims or less than 100 patients)

(ii) Calculation of the Composite Score. The size of an MEC's MIPS payment adjustment will depend on the MEC's performance in four weighted categories during the "performance period."

The performance period will occur two years prior to the application of that score to the MEC's payment. The first MIPS performance period will begin on January 1, 2017 and run through December 31, 2017. The score derived from the MEC's performance during that period will be applied to the MEC's 2019 payment.

Each MEC will be scored on its performance in quality, advancing care information, resource use and clinical practice improvement activities ("CPIAs") categories. The scores from each measure will be aggregated by the Centers for Medicare & Medicaid Services ("CMS") to arrive at a single composite score for each MEC. Composite scores may range from 0 to 100, with 100 as a perfect score.

CMS will then aggregate the composite scores of all MECs and calculate the mean or median (to be decided by the Secretary of DHHS). The mean or median will serve as the "threshold score." If an MEC's composite score is higher than the threshold score, the MEC will receive a payment increase; if the MEC's score is below the threshold score, the MEC will receive a payment decrease.

The payment adjustment to which an MEC may be subject will increase over time:

- 2019—+/ 4%
- 2020—+/ 5%
- 2021—+/ 7%
- 2022 and after—+/ 9%

The size of payment adjustment that an MEC receives will depend on the distance of the MEC's composite score from the threshold score. If an MEC's composite score is close to the threshold, the percentage adjustment will be minimal; if the composite score is far from the threshold, the adjustment will be closer to the maximum. For example, if, in 2019, the threshold score is 50 and an MEC receives a composite score of 55, the MEC's payment increase will be negligible. However, if the MEC receives a composite score of 90, it will likely see a payment increase close to 4%. If the MEC receives a composite score of 10, it will likely see a payment decrease close to 4%.

MIPS also provides additional payment increases to exceptional performers. An MEC whose score falls into the 25th percentile of all composite scores will fall into this category. Exceptional performers may receive an additional payment

increase of up to 10%. Thus, in 2019, an exceptional performer could receive a total payment increase of 14%.

(iii) The MIPS Performance Categories. An MEC's composite score will be based on performance in the abovementioned four weighted categories. The weight assigned to each category will change over time.

[a] Quality. The quality performance category will account for 50% of the MIPS composite score in 2019. This category replaces PQRS but adopts the majority of the PQRS measures. Within the quality category, MECs must report on 6 quality measures (versus the 9 measures currently required) from a list of over 200 measures. The list will be published by the Secretary of DHHS in November of each year. The broad list of measures is intended to provide MECs flexibility to choose the measures most meaningful to their practice. MECs will choose from three categories of measures: cross cutting measures, outcome measures and high priority measures. MECs will be required to report on at least one cross cutting measure and one outcome measure.

While the Secretary of DHHS has not yet published the list of measures for 2019, the measures will likely address topics such as patient safety, patient and caregiver centered experience and outcomes, communication and care coordination, effective clinical care, community and population health, and efficiency and cost reduction.

[b] Advancing Care Information. The advancing care information category will account for 25% of the MIPS composite score in 2019, and replaces the MU program. To perform well in this category, MECs will be required to begin or continue to use certified EHR technology.

The advancing care information score will be based on two components: a base score and a performance score. A clinician may achieve a maximum of 50 points in the base score and 80 points in the performance score. While it is possible for a clinician to achieve a score of 130, a clinician's score will be deemed perfect if it is 100 or above.

The base score component will require yes/no or numerator/denominator responses to each of six categories. MECs must answer "yes" in the yes/no categories to receive full credit. The categories include:

- Protect patient health information (yes/no)

- Patient electronic access (numerator/denominator)
- Coordination of care through patient engagement (numerator/denominator)
- Electronic prescribing (numerator/denominator)
- Health information exchange (numerator/denominator)
- Public health and clinical data registry reporting (yes/no)

The performance score component will permit MECs to report on eight measures from three different objectives. Each measure will be worth 10 points, allowing for a maximum 80 point score. Because MECs need only 50 points to receive a perfect performance score, MECs will have flexibility in focusing on only those measures most relevant to their practice. The point calculation will correspond to the MEC's performance rate. Thus, if an MEC scores a 55% on the measure, the MEC will earn 5.5 points towards its performance score. The eight measures will include:

- Patient electronic access objective
- Patient access measure
- Patient specific measure
- Coordination of care through patient engagement objective
- VDT measure
- iSecure messaging measure
- Patient generated health data measure
- Health information exchange
- Patient care record exchange measure
- Request/accept patient care record measure
- Clinical information reconciliation measure

[c] Resource Use. The resource use category will account for 10% of the composite score in 2019 and will replace VM. Resource use is intended to

determine which MECs are providing high-quality care at a low cost. It is solely claim-based, and therefore will require no additional reporting for MECs.

CMS will continue to use two VM measures—total cost per capita for all attributed beneficiaries and total Medicare spending per beneficiary ("MSPB")—as the basis for scoring. However, MECs in a specialty practice will be scored with "episodic measures" to ensure "apples to apples" comparisons.

[d] CPIAs. The CPIA category will account for 15% of the composite score in 2019. A CPIA is defined as an activity that improves clinical practice or care delivery, and that is likely to result in improved health outcomes.

Any MEC that is certified as a patient centered medical home will automatically receive a perfect score in the CPIA category. For all other MECs, the CPIA score will be based on measures from two weighted categories: medium performance and high performance. In order to achieve the highest potential score of 60 points, an MEC must choose 3 high weighted CPIAs (at 20 points each), 6 medium weighted CPIAs (at 10 points each) or some combination of the two for a total of 60 points. MECs must perform each activity for at least 90 days during the performance period to receive credit for that activity.

The Secretary of DHHS will establish a broad list of activities from which clinicians may choose. However, activities will fall into the following categories:

- Expanded practice access
- Population management
- Care coordination
- Beneficiary engagement
- Patient safety and practice assessment
- Participation in an APM
- Achieving health equity
- Emergency preparedness and response
- Integrated behavioral and mental health

Reinhart

Important Dates

MIPS payment adjustments will begin to apply in 2019. However, the MIPS performance period will begin on January 1, 2017 and run through December 31, 2017. For the 2017 performance period, MECs must report all applicable measures to CMS by March 31, 2018. Additionally, clinicians must submit claims within 90 days of the close of the performance period.