With the repeal of the sustainable growth rate (SGR) behind us, we are moving into a new era of Medicare physician payment under the Medicare Access and CHIP Reauthorization Act (MACRA). Introducing the new Quality Payment Program.

Here is what we know

- MACRA realigns many Medicare program requirements
- There will be 2 main pathways for physician payment under the new quality payment program:
  - Most physicians will begin being paid under MACRA via the modified fee-for-service model called the Merit-based Incentive Payment System (MIPS)
  - There is also an advanced alternative payment model (APM) pathway, in which physicians participating in payment models specifically approved by the Centers for Medicare & Medicaid Services (CMS) can receive an annual bonus payment
- Participation in APMs that fall outside of the advanced models approved by CMS will still help physicians in their performance measurements under MIPS

Here is what we are doing

AAPM&R is strongly advocating to CMS on issues that directly impact physiatry. You can learn more about these by reading our comment letter to CMS dated June 27, 2016 on our website. We are also creating a qualified clinical data registry (QCDR) that will streamline your reporting and assist with MIPS performance scoring. Throughout the next few months, look to AAPM&R for new resources on the Quality Payment Program as we learn more about the regulations.

Here is what you can do

1. **Prepare your practice.** There are steps you can take now to prepare for the transition to the new quality payment program next year, such as participating in a QCDR that streamlines reporting processes. Use the **checklist in this action kit** to get ready.

2. **Stay up-to-date with MACRA and share preparation tips with your colleagues.** Learn more about MACRA in documents provided **in this action kit.** Visit **www.aapmr.org/quality-practice** to access additional resources and information. Be sure to watch and share our informational videos with your colleagues.

MACRA's Quality Payment Program Checklist:

Steps you can take now to prepare

Whether you ultimately participate in an APM or the MIPS, taking action in the following areas can position your practice for success in the future.

General considerations

- ❑ Determine whether you have $10,000 or less in Medicare charges and 100 or fewer Medicare patients annually. If so, you are exempt from MIPS participation.
- ❑ Contact AAPM&R at **spineregistry@aapmr.org** about participating in our data registry to streamline your reporting and assist with MIPS performance scoring.
- ❑ Physicians in a practice of more than 1 eligible clinician should decide whether to report individually or as a group.
- ❑ Determine whether your practice meets the requirements for small, rural or non-patient-facing physician accommodations.

MIPS: Resource use

- ❑ Check your Medicare quality and resource use reports (QRURs) to see where improvement can potentially be made.
- ❑ Review CMS's proposed list of episode groups at **www.cms.gov**.
- ❑ Identify your most costly patient population conditions and diagnoses.
- ❑ Identify targeted care delivery plans for these conditions.
- ❑ Identify any internal workflow changes that can be made to support care delivery plans.
- ❑ Identify potential partners outside of your practice to advance a coordinated care plan (e.g., other specialists to whom you refer patients).

MIPS: Quality measurement and reporting

- ❑ Check your Medicare Physician Quality Reporting System (PQRS) feedback reports. Make sure that you understand your current quality metrics reporting requirements and how you are scoring across both PQRS and private payers. While it is anticipated that the general PQRS requirements will stay the same under MIPS, there are some proposed changes to MIPS quality requirements and quality measures. Determine which quality measures you plan to report on; there are individual measures and specialty-specific measure sets.
- ❑ Access and review the 2014 annual PQRS feedback reports to see where improvements can be made. Authorized representatives of group and solo practitioners can view the reports on the CMS Enterprise Portal using an Enterprise Identity Data Management account with the correct role.
- ❑ Consider whether you plan to report through claims, electronic health record (EHR), clinical registry, qualified clinical data registry (QCDR) or group practice reporting option (GPRO) Web-interface. The GPRO Web-interface is only available for physicians in practices of 25 or more eligible clinicians.
- ❑ Seek out local support for your quality improvement activities. Many local organizations such as Practice Transformation Networks provide resources and technical support—often free of charge—to help small physician practices succeed.

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MIPS: Clinical practice improvement activities

- ❑ Review the proposed rule's list of clinical practice improvement activities (CPIAs) to evaluate what activities your practice is already doing and what adjustments it should make to complete additional activities in 2017.
- ❑ The reporting period for CPIAs is 90 days. Consider which 90 days in 2017 would work best for your practice's selected CPIAs.
- ❑ If you participate in a nationally recognized, accredited patient-centered medical home (PCMH), a Medicaid medical home model, a medical home model, or are recognized by the National Committee for Quality Assurance as a patient-centered specialty model, ensure that your certifications and accreditations (as applicable) are current. Physicians participating in these medical homes earn full CPIA credit.

MIPS: Advancing Care Information

- ❑ If you have an EHR, make sure it is certified EHR technology, which is often referred to as CEHRT. Determine whether it is 2014- or 2015-edition certified health information technology; the version will determine the measures on which you report in 2017.
- ❑ Speak with your vendor about how their product supports new payment model adoption. For example: How does their product support Medicare quality reporting? Document these conversations.
- ❑ Consider how to ensure that you can report at least one unique patient (or answer "yes," as applicable) for each measure of the base score's 6 objectives. Ideas include:
  - Reach out to existing patients to encourage their use of patient portals to view, download and transmit their health information in 2017.
  - Your EHR may allow you to send a secure message through the patient portal to all of your patients at once—if so, and doing so is appropriate for your practice, consider sending an appointment reminder to all of your patients in 2017.
- ❑ Conduct a careful security risk analysis in early 2017. Failure to properly do so will result in a score of zero for this category. Your risk analysis should comply with the HIPAA Security Rule requirements. The AMA website has resources to help with this step at **www.ama-assn.org/go/hipaa.**
- ❑ Determine whether there is an additional public health registry to which you can report to receive an additional point towards your total Advancing Care Information score.

Alternative payment models

- ❑ Confirm whether you are a participant in any of the advanced APMs.
- ❑ Evaluate whether you are likely to meet the threshold for significant participation in an advanced APM, which would qualify you for incentive payments.
- ❑ Determine whether 50 percent of your clinicians use certified EHR technology to document and communicate clinical care information.

"Pick Your Pace" in 2017

The final MACRA regulation will exempt physicians from any risk of penalties if they choose 1 of 3 distinct MIPS reporting options in 2017, in addition to the option of participating in an advanced APM:

- ❑ Full-year reporting that begins on January 1, 2017–eligible for a modest positive payment adjustment.
- ❑ Partial year reporting for a reduced number of days–eligible for a small positive payment adjustment.
- ❑ A "test" option under which physicians can report minimal amounts of data–not subject to any payment adjustment.

Stay tuned to
www.aapmr.org/quality-practice
after November 1 for final rule information.

Medicare Access and CHIP Reauthorization Act Proposed Rule Overview

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was passed by the U.S. House of Representatives on March 26, 2015 (by a vote of 392 to 37), and the Senate on April 14, 2015 (by a vote of 92 to 8), and signed into law on April 16, 2015. This bipartisan legislation permanently repeals the sustainable growth rate formula. Medicine strongly supported this bill.

Currently, physicians participate in several overlapping Medicare reporting programs—the electronic health records incentive program (Meaningful Use or MU), the Physician Quality Reporting System (PQRS) and the value-based modifier (VBM).

MACRA replaces these programs with the **Merit-based Incentive Payment System (MIPS)**, which consolidates and better aligns these reporting programs to simplify them and reduce physicians' administrative burdens. It also adds a new clinical practice improvement activities component with more than 90 activities from which physicians can choose to receive credit for providing high-value services. Physicians with annual Medicare billing charges less than or equal to $10,000 who provide care for 100 or fewer Part B-enrolled Medicare beneficiaries (the low-volume threshold) are exempt from MIPS.

Without the passage of MACRA, physicians could have been subject to negative payment adjustments of 11% or more in 2019 as a result of the MU, PQRS and VBM programs, with even greater penalties in future years. In contrast, under MACRA, the largest penalty a physician can experience in 2019 is 4%. MACRA also provides incentives for physicians to develop and participate in different models of health care delivery and payment known as **alternative payment models (APMs)**.

The Centers for Medicare & Medicaid Services (CMS) has released its initial proposal to implement MACRA. This is a proposed rule. Andy Slavitt, CMS's acting administrator, has clearly stated that the administration is interested in the physician community's feedback so that the agency can make changes in the final rule. AAPM&R will continue to actively engage the administration and Congress and work with the federation as we seek to secure changes in the final rule.

MIPS program structure

- The following 4 components are scored individually and then combined to create a composite score. Each physician's score will result in a positive, negative, or neutral payment adjustment.
  - **Quality performance**—50% of score in the first year (replaces PQRS and some components of the VBM)
  - **Resource use**—10% of score in the first year (replaces the cost component of the VBM)
  - **Clinical practice improvement activities**—15% of score in the first year
  - **Advancing Care Information**—25% of score in the first year (replaces MU)

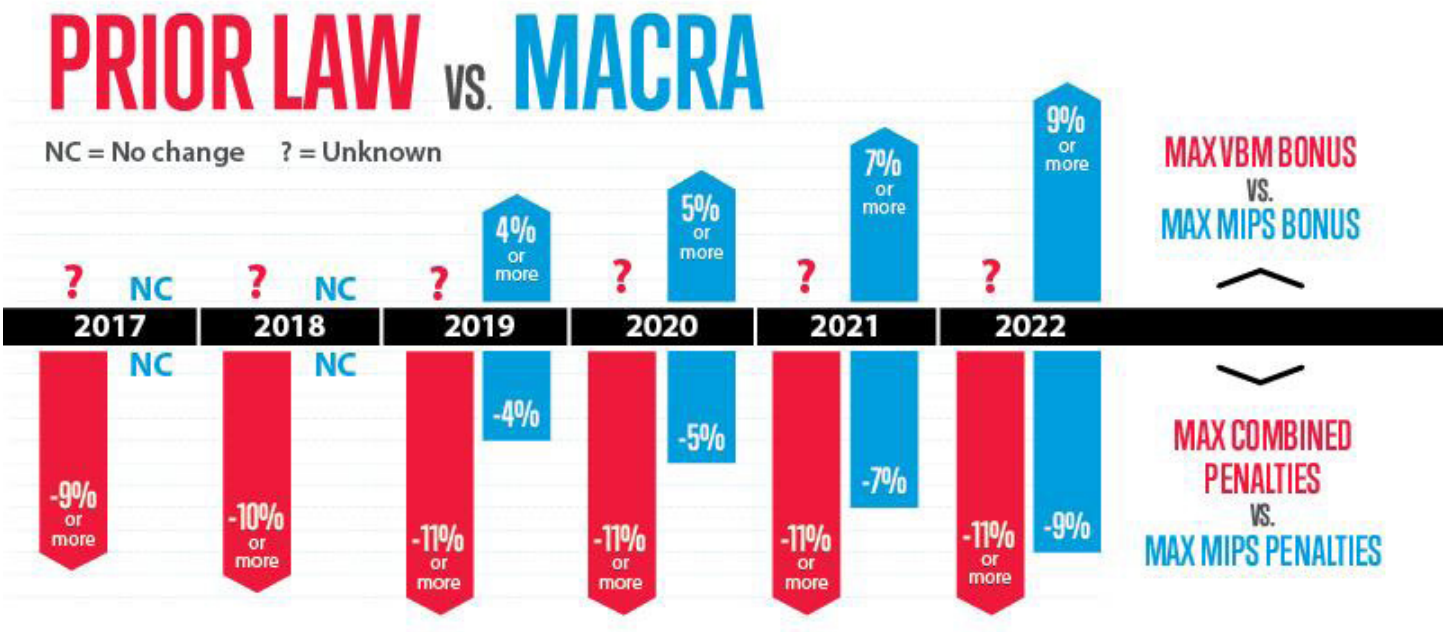
APMs

- Qualifying physicians in advanced APMs are eligible for a 5% bonus and are exempt from MIPS.
- MIPS APM participants—that is, those APM participants who do not qualify for the 5% bonus—will receive extra credit in their MIPS scoring.

Rewards and Penalties Under MACRA's Merit-based Incentive Payment System

Under the Medicare Access and Chip Reauthorization Act (MACRA), physicians who remain in Medicare's fee-for-service program will be participants in the Merit-based Incentive Payment System, or MIPS. While AAPM&R continues to press for improvements in the regulatory framework for implementing MIPS, there is no question that the system offers significant improvements over previous Medicare law.

- MIPS consolidates and better aligns the separate quality and performance measurement programs that affected physician payments previously—the electronic health records Meaningful Use program, the Physician Quality Reporting System (PQRS), and the value-based modifier (VBM). It adds a new component, clinical practice improvement activities, with a menu of over 90 activities demonstrating high-value services for which physicians can receive credit.
- Under previous law, each of these separate programs included quality measures that were overlapping and sometimes conflicting. For example, a physician who did not successfully report under PQRS automatically received a second negative payment adjustment under the VBM. Under MIPS, that will no longer be the case.
- The previous Meaningful Use and PQRS programs also were scored on a pass/fail approach, which required physicians to be 100% successful on all reporting requirements in order to avoid a payment penalty. Under MIPS, physicians will receive partial credit for elements on which they are able to report successfully.
- Additionally, the aggregate financial risk of financial penalties under MIPS is significantly less than it was under the previous system as the table below illustrates.



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Clinical Practice Improvement Activities (CPIA)

Key Changes

- **Offers choice:** The rule proposes to allow physicians to select from a list of more than 90 activities from which to receive credit under the Merit-based Incentive Performance System (MIPS).

  Activities that would count for CPIA include participation in a qualified clinical data registry, such as AAPM&R's spine registry. Contact us at **spineregistry@aapmr.org** to learn more about participating.

- **Creates a shorter reporting period:** Rather than requiring a full year of reporting, CPIA activities would be performed for at least 90 days during the performance period.

- **Promotes medical homes and alternative payment models:**
  - A patient-centered medical home (PCMH) would receive full CPIA credit if it is a nationally recognized accredited PCMH, a Medicaid medical home model, a medical home model or has a patient-centered specialty recognition from the National Committee for Quality Assurance.
  - Participation in an alternative payment model would receive half credit.

- **Provides accommodations for small, rural and non-patient-facing physicians:** Under the proposal, these physicians would need to meet a lower reporting threshold.

- **Proposes a simple reporting process:** As proposed, physicians will report CPIA activities generally through attestation.

Quality Category

(replaces the Physician Quality Reporting System)

Key Changes

- **Reduces reporting burden:** Physicians report on 6 measures rather than 9 and no longer have to pick at least 3 measures from the national quality strategy domains. Physicians can also receive partial credit for reporting on a measure.

- **Offers flexibility:** Physicians can:
  - Select individual measures or specialty specific measure sets
  - Report through either claims, electronic health record (EHR), clinical registry, qualified clinical data registry (QCDR) or group practice reporting Web-interface
  - Report as either an individual or a group

- **Provide bonuses:** Recognizing the cost to report through electronic sources and the effort to report outcome measures, the Centers for Medicare & Medicaid Services (CMS) provides capped bonuses to physicians who choose to report quality measures through an EHR, qualified registry, QCDR or Webinterface. Bonus points can also be earned for reporting on additional outcome measures and measures in high-priority areas, such as appropriate use, patient safety, efficiency, patient experience or care coordination.

Resource Use Category
(replaces value-based modifier)

Key Changes

- **Transitions to episode-based measures:** The Centers for Medicare & Medicaid Services (CMS) proposes to add 41 episode-based measures to account for differences among specialties. Episode groups have the potential to more appropriately measure resource use and provide more actionable feedback than cost measures.
- **Recognizes the need for improved attribution:** CMS plans on making refinements to its attribution methodology starting in 2018.

Advancing Care Information
(replaces Meaningful Use)

Key Changes

- **New scoring:** Moves away from a pass-fail program design by combining a base score and performance score into an overall Advancing Care Information (ACI) score.
  - The base score (worth 50% of the overall ACI score) only requires attestation or simple yes/no options.
  - The performance score does not use thresholds and allows physicians to receive partial credit on measures.
  - Physicians can also receive a bonus point for reporting to multiple public health and clinical data registries.
- **Reduces measures:** No longer requires physicians to report on 2 measures that hindered usability—computerized provider order entry, known as CPOE, and clinical decision support, known as CDS. Removes clinical quality measures to streamline overall quality reporting in Merit-based Incentive Payment System, or MIPS, and simplifies the public health and clinical data registry reporting requirements.
- **Eased reporting processes:** Allows group data submission and performance to be assessed as a group (as opposed to the individual clinician). Permits physicians to submit data for the first time through qualified clinical data registries, known as QCDRs.

Alternative Payment Models (APMs)

Key Changes

- **Simplicity in quality requirements:** The rule proposes that advanced APMs, which are those that qualify physicians for the 5% lump-sum bonus payments, link some—but not all—payments to quality measures and allows significant flexibility in choice of measures.
- **Flexible approach to electronic health records (EHR) use:** In the first performance year, advanced APMs must require at least 50% of participants to use certified EHR technology, with use broadly defined, rising to 75% the following year.
- **Several policies help physicians meet qualified participant (QP) thresholds:** Patient thresholds to meet the QP standard are well below revenue thresholds in the Medicare Access and CHIP Reauthorization Act, known as MACRA.
- **Advantages for the Merit-based Incentive Payment System (MIPS) APM participants:** Physicians participating in some types of APMs, which do not meet criteria to be advanced APMs, would benefit from modifications to MIPS components likely to help them earn a high MIPS score.