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# 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.

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## 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. 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](http://www.aapmr.org/quality-practice) to access additional resources and information. Be sure to watch and share our informational videos with your colleagues.

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# MACRA's Quality Payment Program Checklist:

## Steps you can take now to prepare

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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 \$30,000 or less in Medicare charges OR 100 or fewer Medicare patients annually. If so, you are exempt from MIPS participation. CMS will alert those who are exempt prior to the reporting year.
- ❑ Contact AAPM&R at [spineregistry@aapmr.org](mailto: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: 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. 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: Improvement Activities

- ❑ Review the list of improvement activities (IAs) 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](http://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.

## 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](http://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).

## 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.

Stay tuned to  
[www.aapmr.org/quality-practice](http://www.aapmr.org/quality-practice)  
after November 1 for final rule information.

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# Medicare Access and CHIP Reauthorization Act Proposed Rule Overview

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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 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 \$30,000 or 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)**.

## 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. In 2017, the weights for each category are as follows:
  - ◆ **Quality performance**—60% of score in the first year (replaces PQRS and some components of the VBM)
  - ◆ **Improvement activities**—15% of score in the first year
  - ◆ **Advancing Care Information**—25% of score in the first year (replaces MU)
  - ◆ **Resource use**—0% of score in the first year (replaces the cost component of the VBM)

## APMs

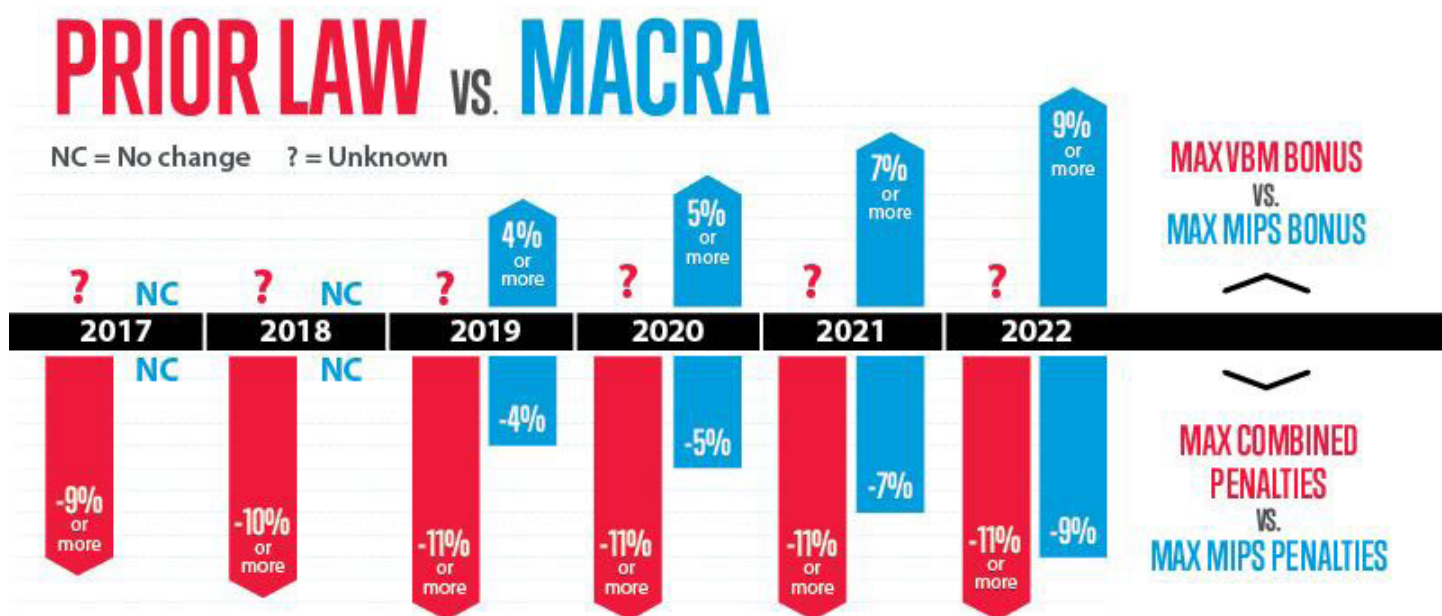
- Qualifying physicians in advanced APMs are eligible for a 5% bonus and are exempt from MIPS.
- MIPS APM participants—that is, those APM participants who do not qualify for the 5% bonus—will receive extra credit in their MIPS scoring.

# 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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# How will the Quality Payment Program change my Medicare payments?

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The Depending on the track of the Quality Payment Program you choose and the data you submit by March 31, 2018, your 2019 Medicare payments will be adjusted up, down, or not at all. The information provided below is only relevant for the 2019 payment year. CMS will provide additional information on payment adjustments for 2020 and beyond beginning next year.

**Pick your pace in MIPS: If you choose the MIPS track of the Quality Payment Program, you have three options.**



## Don't Participate

**Not participating in the Quality Payment Program:** If you don't send in any 2017 data, then you receive a negative 4% payment adjustment.

## Submit Something

**Test:** If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity), you can avoid a downward payment adjustment.

## Submit a Partial Year

**Partial:** If you submit 90 days of some 2017 data to Medicare, you may earn a small positive payment adjustment.

## Submit a Full Year



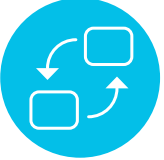




**Full:** If you submit 90 days to a full year of all 2017 data to Medicare, you may earn a moderate positive payment adjustment.

**The size of your payment adjustment will depend both on how much data you submit and your quality results.**

**Participate in the Advanced APM track:** If you receive 25% of Medicare covered professional services or see 20% of your Medicare patients through an Advanced APM in 2017, then you earn a 5% Medicare incentive payment in 2019.



# What do you need to do for MIPS?

Category	What do you need to do?	2017 category weight
<b>Quality</b> 	<p><b>Most participants:</b> Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days.</p> <p><b>Groups using the web interface:</b> Report 15 quality measures for a full year.</p> <p><b>Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Track 1 or the Oncology Care Model:</b> Report quality measures through your APM. You do not need to do anything additional for MIPS quality.</p>	
<b>Improvement Activities</b> 	<p><b>Most participants:</b> Attest that you completed up to 4 improvement activities for a minimum of 90 days.</p> <p><b>Groups with fewer than 15 participants or if you are in a rural or health professional shortage area:</b> Attest that you completed up to 2 activities for a minimum of 90 days.</p> <p><b>Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model:</b> You will automatically earn full credit.</p> <p><b>Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Program Track 1 or Oncology Care Model:</b> You will automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.</p> <p><b>Participants in any other APM:</b> You will automatically earn half credit and may report additional activities to increase your score.</p>	
<b>Advancing Care Information</b> 	<p><b>Fulfill the required measures for a minimum of 90 days:</b></p> <ul style="list-style-type: none"> <li>◆ Security Risk Analysis</li> <li>◆ e-Prescribing</li> <li>◆ Provide Patient Access</li> <li>◆ Send Summary of Care</li> <li>◆ Request/Accept Summary of Care</li> </ul> <p>Choose to submit up to 9 measures for a minimum of 90 days for additional credit.</p> <p>- OR -</p> <p>You may not need to submit Advancing Care Information if these measures do not apply to you.</p>	
<b>Cost</b> 	<p>No data submission required. Calculated from adjudicated claims.</p>	<p>Counted starting in 2018.</p>

# What are Advanced Alternative Payment Models (APMs)?

An Alternative Payment Model (APM) is a payment approach, developed in partnership with the clinician community, that provides added incentives to clinicians to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. Advanced APMs are a subset of APMs and let practices earn more for taking on some risk related to patients' outcomes. You may earn a 5% Medicare incentive payment during 2019 through 2024 and be exempt from MIPS reporting requirements and payment adjustments if you have sufficient participation in an Advanced APM. Earning an incentive payment in one year does not guarantee receiving the incentive payment in future years.

## Advanced APMs must meet the following requirements:

- Be CMS Innovation Center models, Shared Savings Program tracks, or certain federal demonstration programs
- Require participants to use certified EHR technology
- Base payments for services on quality measures comparable to those in MIPS
- Be a Medical Home Model expanded under Innovation Center authority or require participants to bear more than nominal financial risk for losses. The final rule with comment period defined the risk requirement for an Advanced APM to be in terms of either total Medicare expenditures or participating organizations' Medicare revenue (which may vary significantly). This enhanced flexibility allows for the creation of more Advanced APMs tailored to physicians and other clinicians, such as advanced practice nurses, generally, and small practice participation in particular.

In order to qualify for the 5% APM incentive payment for participating in an Advanced APM during a payment year, you must receive a certain percentage of payments for covered professional services or see a certain percentage of patients through the Advanced APM during the associated performance year.

**Table 1: Requirements for APM Incentive Payments for Participation in Advanced APMs  
(Clinicians must meet payment or patient requirements)**

Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Medicare Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Medicare Patients through an Advanced APM	20%	20%	35%	35%	50%	50%