Medicare Access and CHIP Reauthorization Act of 2015: Medicare Incentive Payment System

How It Affects You and Your Practice

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The Sustainable Growth Rate

SGR was a method used by CMS to control Medicare spending on physician fees and services.

The four factors used in calculating the SGR were:

- Estimated % change in physician fees
- Estimated % change in number of Medicare fee-for-service beneficiaries
- Estimated 10-year average annual % change in real GDP per capita
- Estimated % change in expenditures because of laws or regulations

https://www.cms.gov/medicare/medicare-fee-for-service-payment/sustainablegratesconfact/downloads/sgr2015p.pdf

SGR Repeal and MACRA

- Congress achieved the often-eluded goal of repealing the SGR in 2015
  - Physicians faced a staggering 21.2% cut in payments starting on April 1, 2015
- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) instead replaced SGR with alternative payment models
- This change represents CMS' transition away from reimbursement based on fee-for-service to reimbursement based on quality (among other factors)

Remember…

- You must still participate in PQRS, meaningful use reporting, and the value-based modifier for 2016
- The outcomes of these reporting programs will determine 2018 payments
- MIPS/APM will not take effect until 2019 payments

So what does this mean for today's foot and ankle surgeon?

Annual Medicare Physician Fee Schedule Services Update

January 2015 – June 2015	July 2015 – 2019	2020 – 2025	2026 +
0%	.5%	0%	Either .75% (APM participants) OR .25% (all others)

Your Medicare reimbursement rates will increase by the above percentages per year, but you have the opportunity to earn bonuses based on high-quality, high-value health care with new payment and new delivery models.

Merit-based Incentive Payment (MIPS)

- Intended to integrate and simplify several of the current CMS quality programs (the Base EHR portion of Meaningful Use, PQRS, and the value based payment modifier)
- Performance and “composite scores” will be based on four categories:
  - Clinical practice improvement activities
  - Quality/PQRS
  - Meaningful use
  - Resource use/value based modifier

Who Qualifies as a MIPS eligible clinician?

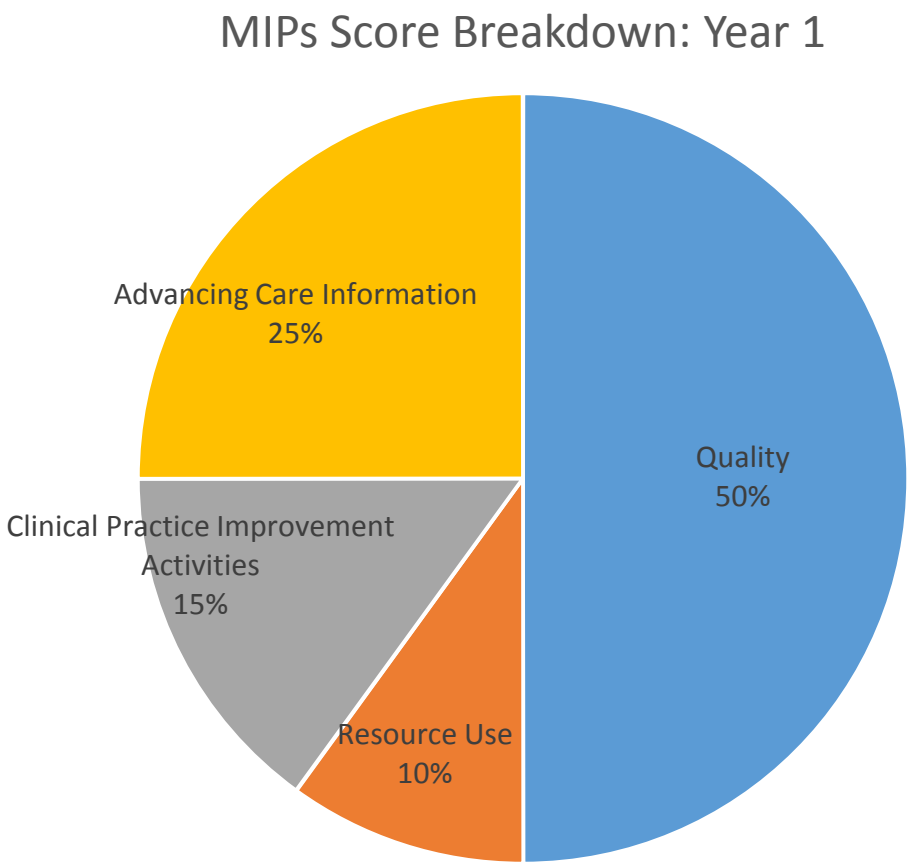
- Years 1 + 2
  - Physicians (MD/DO, DMD/DDS, DPM)
    - *Note: CMS has some different rules for non-patient facing clinicians, like radiologists or pathologists
  - A majority of mid-level providers: Physician assistants, nurse practitioners, clinical nurse specialists, CRNAs

- Years 3+
  - The expansion of MIPS eligible clinicians is dependent upon whether or not the Secretary broadens the definition of eligible clinicians
  - May include physical or occupational therapists, audiologists, nurse midwives, clinical social workers, clinical psychologists, dietitians/nutritional professionals

Who DOESN'T Qualify for MIPS?

- Physicians who participate in alternative payment models (APMs)
- Physicians who partially qualify for APMs
- Low-volume threshold eligible clinicians (have less than or equal to $10,000 in Medicare charges and less than or equal to 100 Medicare patients)
- Physicians in their first year of Medicare Part B participation (in 2017)
- MIPS does not apply to hospitals or facilities

MIPS Score, Year 1



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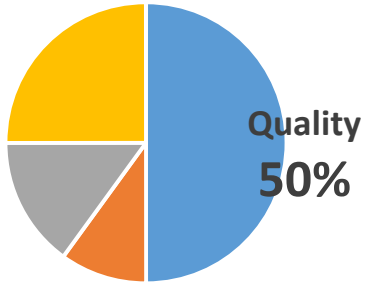
MIPS Score Breakdown: Quality



- Replaces the Physician Quality Reporting System and the quality of the Value Modifier Program
- You (the physician) would **choose** which six measures to report (not nine as currently required under PQRS)
  - 1 cross-cutting measure and 1 outcome measure, or another high priority measure if outcome is unavailable
  - If an outcome measure is not available, you would be required to report on one other high priority measure (appropriate use, patient safety, efficiency, patient experience, and care coordination measures)
  - If less than six measures apply, you would be required to report on each measure that is applicable
- Changes from PQRS: reduced measures with NO DOMAIN requirement; emphasis on outcome measurement

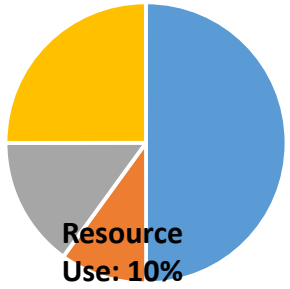
MIPS Score Breakdown: Quality

MIPS ID Number	NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Data submission Method	Measure Type	Measure Title and Description‡	Measure Steward
* § !	0059/001	122 v4	Effective Clinical Care	Claims, Web Interface, Registry, EHR	Intermediate Outcome	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%): Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	National Committee for Quality Assurance
§	0081/005	135 v4	Effective Clinical Care	Registry, EHR	Process	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD): Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.	American Medical Association-Physician Consortium for Performance Improvement/ American College of Cardiology Foundation/ American Heart Association

See page 773 of the proposed rule

To the left is an example of what sort of quality measures CMS will ask physicians to report on. The proposed rule contains a list of 300 proposed quality measures.

MIPS Score Breakdown: Resource Use



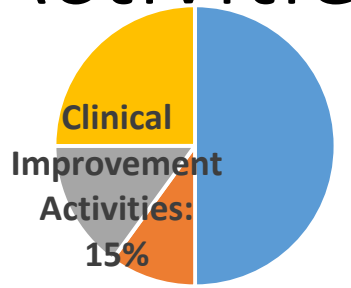
- The goal of this measure is to “provide MIPS eligible clinicians with the information they need to provide appropriate care to their patients and enhance health outcomes.”
- All resource use measures would be adjusted for geographic rate adjustments and beneficiary risk factors, in addition to a specialty adjustment applied to the total per capita cost measure
- If you do not have enough attributed cases to meet or exceed case minimums, you would not be measured on resource use
- Good news: CMS would calculate this for you: no need for you to submit additional data
  - CMS would calculate this score utilizing administrative claims data
- Key changes:
  - Adding 40 + episode specific measures to address specialty concerns
  - Year 1 weight: 10%

MIPS Score Breakdown: Resource Use

- To combat some of the problems posed by differences in resource uses (differences in patient needs, lack of control of patient population), CMS has created three new ways to classify services and patients:
  - Care Episode Groups would define what procedures or services are utilized in the clinical decision making process. CMS wants to create measures that are more accurate in defining what services or costs the physician actively controls.
  - Patient Relationship Categories would delineate the “relationship and responsibility” of a practitioner against a patient when services are rendered. CMS wants to be able to accurately account for payments and spending.
  - Patient Condition Groups is based on outside factors, like overall patient health status, chronic co-morbid conditions, or other significant health events. CMS hopes to more accurately define how they risk adjust patients.

http://www.chqpr.org/downloads/ImprovingResourceUseMeasurementUnderMACRA.pdf

MIPS Score Breakdown: Clinical Improvement Activities

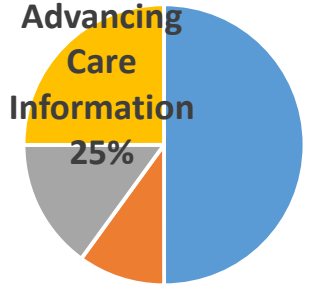


- The category is meant to be patient-centered and emphasize making decisions that have proven positive health outcomes
- Requirements: At least 1 activity from over 90+ proposed activities, additional credit for more activities, full credit for participating in a patient-centered medical home, minimum half credit for participating in an alternative payment model
- Examples include care coordination, shared decision-making, safety checklists, expanding practice access
- To reach 100% of the total CPIA, you would need to reach 60 points by performing clinical practice improvement activities
  - A medium-level activity will be scored 10 points; a high-level activity will be scored 20 points

Clinical Improvement Activities: What Can I Do?

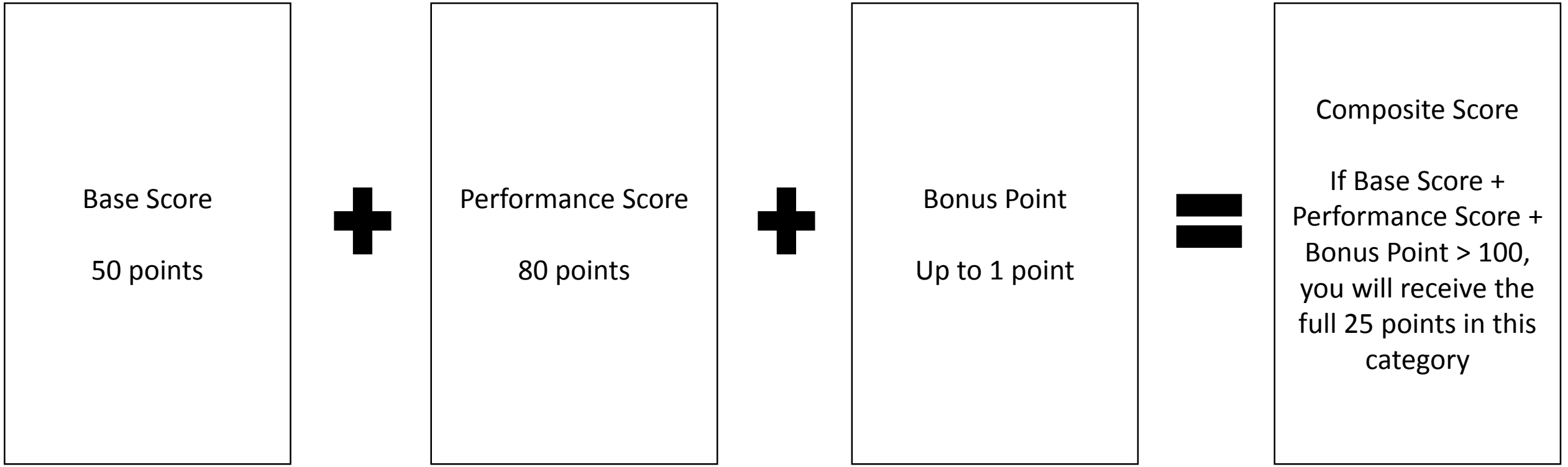
- Good news: If you are a small practice, practice in a rural area, or work in a geographic health professional shortage area (HPSA), you can submit a minimum of one activity of any weighting to achieve partial credit or two activities of any weighting to achieve full credit
- CPIA Categories:
  - Expanded access (same day appointments, after-hours access to clinicians)
  - Population management
  - Care coordination
  - Beneficiary engagement
  - Patient safety & practice assessment

Advancing Care Information



- This will replace meaningful use
- Measure is meant to emphasize patient care and information access
- Meant to evaluate your use of EHR technology
- The basis of this measure is Stage 3 EHR meaningful use
- 3 areas make up full composite score

Advancing Care Information: Scoring



https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Advancing-Care-Information-Presentation.pdf

Advancing Care Information: Base Score

- Must prove numerator/denominator or yes/no for each objective and measure
- Six proposed measures to report:
  - Protecting patient health information
  - Electronic prescribing
  - Patient electronic access
  - Coordination of care through patient engagement
  - Health information exchange
  - Public health and clinical data registry reporting

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Advancing-Care-Information-Presentation.pdf

Base Score Objective and Measure Reporting Proposals

Proposal 1

TABLE 6: Base Score Primary Proposal Advancing Care Information Objective and Measure Reporting*

	Objective	Measure*	Total Base Score
1	Protect Patient Health Information	Security Risk Analysis	50 %
2	Electronic Prescribing	ePrescribing	
3	Patient Electronic Access	Patient Access	
		Patient-Specific Education	
4	Coordination of Care Through Patient Engagement	View, Download or Transmit (VDT)	
		Secure Messaging	
		Patient-Generated Health Data	
5	Health Information Exchange	Patient Care Record Exchange	
		Request/Accept Patient Care Record	
		Clinical Information Reconciliation	
6	Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting	
		(Optional) Syndromic Surveillance Reporting	
		(Optional) Electronic Case Reporting	
		(Optional) Public Health Registry Reporting	
		(Optional) Clinical Data Registry Reporting	

Department of Health and Human Services; Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee S
Criteria for Physician-Focused Payment Models; Proposed Rule, 81 Federal Register 89,28162 (May 9, 2016)

Base Score Objective and Measure Reporting Proposals

Proposal 2

Objectives 3 and 4 are added in this proposal

TABLE 7: Base Score Alternate Proposal Advancing Care Information Objective and Measure Reporting

	Objective	Measure*	Total Base Score
1	Protect Patient Health Information	Security Risk Analysis	50 %
2	Electronic Prescribing	ePrescribing	
3	Clinical Decision Support (CDS)	Clinical Decision Support (CDS) Interventions	
		Drug Interaction and Drug-Allergy Checks	
4	Computerized Provider Order Entry (CPOE)	Medication Orders	
		Laboratory Orders	
		Diagnostic Imaging Orders	
5	Patient Electronic Access	Patient Access	
		Patient-Specific Education	
6	Coordination of Care Through Patient Engagement	View, Download or Transmit (VDT)	
		Secure Messaging	
		Patient-Generated Health Data	
7	Health Information Exchange	Patient Care Record Exchange	
		Request/Accept Patient Care Record	
		Clinical Information Reconciliation	
8	Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting	
		(Optional) Syndromic Surveillance Reporting	
		(Optional) Electronic Case Reporting	
		(Optional) Public Health Registry Reporting	
		(Optional) Clinical Data Registry Reporting	

Department of Health and Human Services; Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule, 81 Federal Register 89,28162 (May 9, 2016)

TABLE 8: Base Score Modified Primary and Alternate Proposals Advancing Care Information Objective and Measure Reporting for Modified Stage 2 (in 2017)

Objective	Measure for MIPS (in 2017 only)**	Total Base Score
Protect Patient Health Information	Security Risk Analysis	50%
Electronic Prescribing	ePrescribing	
Clinical Decision Support (CDS)*	Clinical Decision Support (CDS) Interventions	
	Drug Interaction and Drug-Allergy Checks	

Objective	Measure for MIPS (in 2017 only)**	Total Base Score
Computerized Provider Order Entry (CPOE)*	Medication Orders	
	Laboratory Orders	
	Diagnostic Imaging Orders	
Patient Electronic Access	Patient Access	
	View, Download, or Transmit (VDT)	
Patient-Specific Education	Patient-Specific Education	
Secure Messaging	Secure Messaging	
Health Information Exchange	Health Information Exchange	
Medication Reconciliation	Medication Reconciliation	
Public Health Reporting	Immunization Registry Reporting	
	Syndromic Surveillance Reporting	
	Specialized Registry Reporting	

*Included in base score alternate proposal only.
**More detailed specifications can be found in section II.E.5.g.7.

CMS streamlined EHR Incentive Program reporting in 2015 by adopting a single set of objectives and measures. The objectives and measures listed to the left are proposed for 2017 reporting

Department of Health and Human Services; Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule, 81 Federal Register 89,28162 (May 9, 2016)

Advancing Care Information: Performance Score

- You can pick measures that best fit your practice
- Proposed objectives:
  - Patient electronic access
  - Coordination of care through patient engagement
  - Health information exchange
- Key changes from EHR Incentive Program:
  - No longer “all or nothing”
  - Repeated or redundant measures removed
  - Clinical Provider Order Entry and Clinical Decision Support objectives removed
  - Reduced number of public health registries to report to
  - Only 25% of total scoring weight in year 1

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Advancing-Care-Information-Presentation.pdf

TABLE 9: Sample Performance Score

Objectives	Patient Electronic Access		Coordination of Care Through Patient Engagement			Health Information Exchange (HIE)		
Measures	Patient Access	Patient-Specific Education	VDT	Secure Messaging	Patient-Generated health Data	Patient Care Record Exchange	Request/ Accept Patient Care Record	Clinical Information Reconciliation
Performance Rate Score								
	95%							
		65%						
								57%
			33%	31%			38%	
					25%	21%		
Percentage Points Earned	9.5%	6.5%	3.3%	3.1%	2.5%	2.1%	3.8%	5.7%
Performance Score = 36.5 percent								

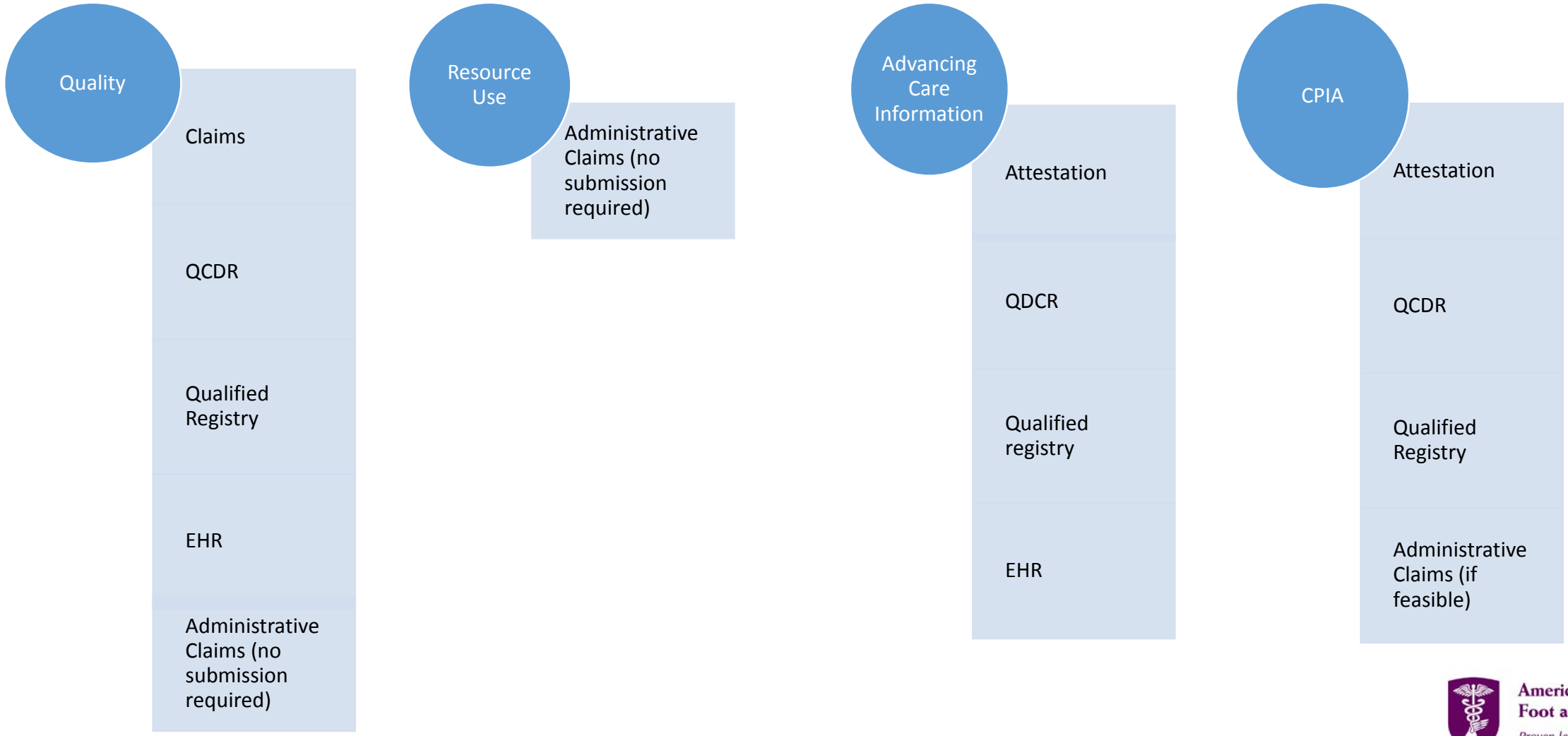
Department of Health and Human Services; Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule, 81 Federal Register 89,28162 (May 9, 2016)

TABLE 10: Sample Advancing Care Information Performance Category Score

Base Score		Performance Score Components									
Protect Patient Health Information	Objectives and Measures	Patient Electronic Access		Coordination of Care Through Patient Engagement			Health Information Exchange			Total Performance Score	Public Health and Clinical Data Registry Bonus Point	Total Percentage
50%		9.5%	6.5%	3.3%	3.1%	2.5%	2.1%	3.8%	5.7%	36.5 %	1%	87.5%
87.5% of 25 possible percentage points = 21.88 percentage points for the advancing care information performance category												

Department of Health and Human Services; Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule, 81 Federal Register 89,28162 (May 9, 2016)

How to Submit Data for MIPS Scoring: Individuals



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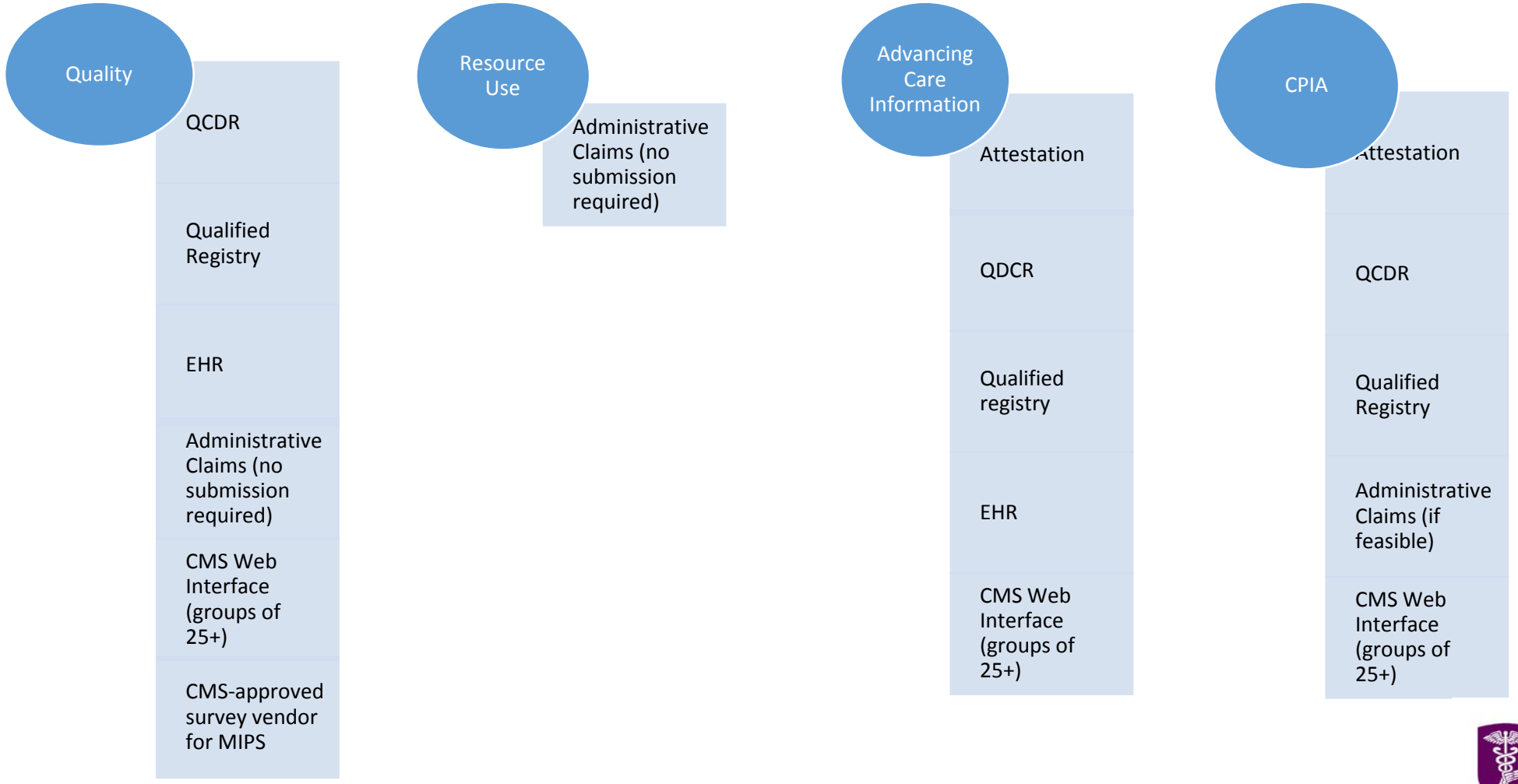
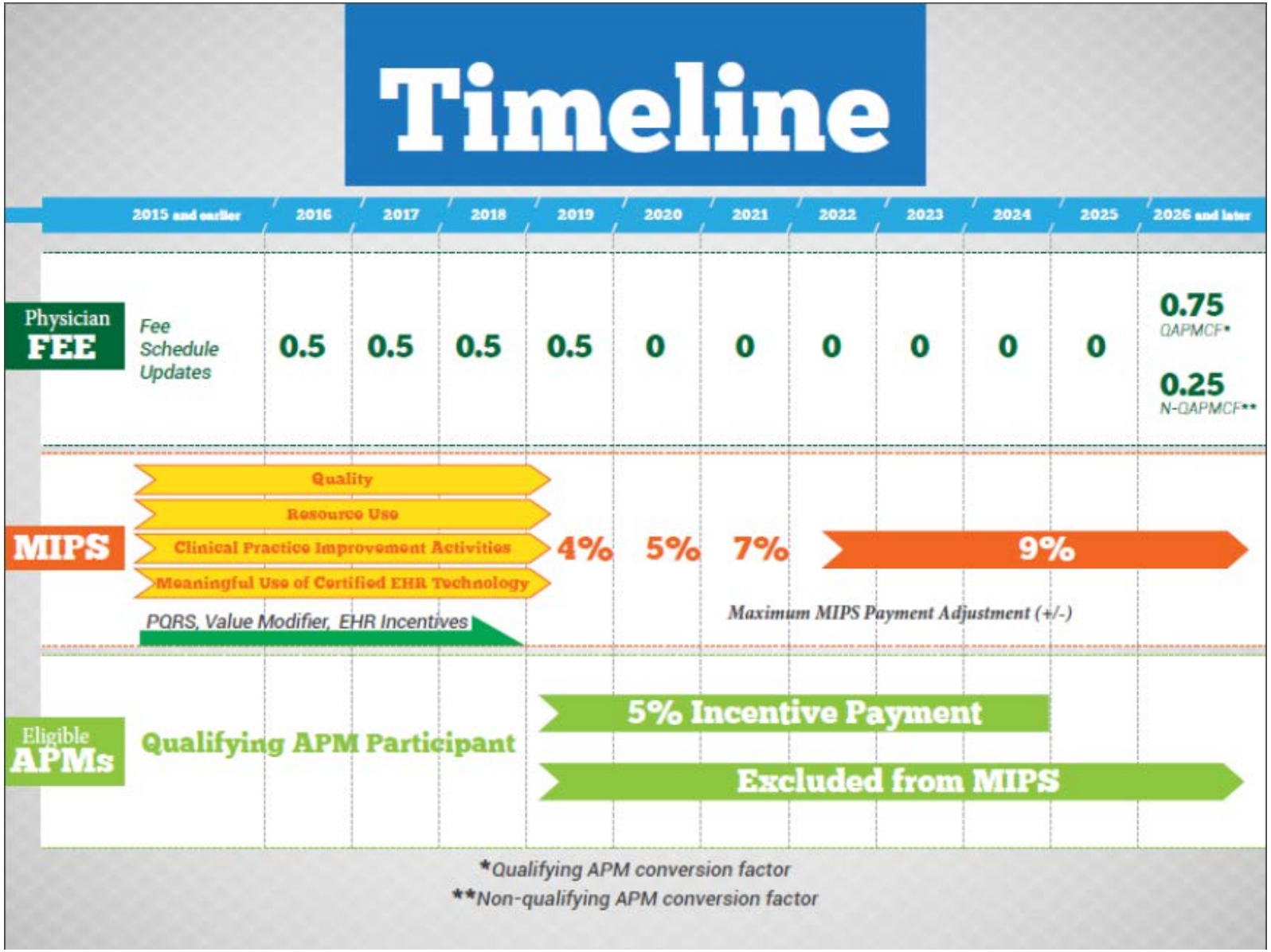
How to Submit Data for MIPS Scoring: Groups





https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Timeline.PDF

Other Resources

- CMS: Quality Payment Program
- CMS: Draft of Quality Measure Development Plan
- MACRA Proposed Regulation
- American Medical Association's Medicare Payment Reform

Stay tuned for materials on MACRA's Alternative Payment Models