KERN AUGUSTINE, P.C.

Attorneys to Health Professionals

Medicare Access and CHIP Reauthorization Act of 2015:
The Future of Medicare Reimbursement – An Introduction

BY:

R. Bruce Crelin
BCrelin@DrLaw.com

On April 16, 2015, President Obama signed the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") into law. In an earlier series of articles, we explained MACRA under the proposed regulations which had been promulgated. Final regulations have now been issued, and there are several significant changes from the proposed regulations. The "Quality Payment Program," which replaced the heavily criticized "Sustainable Growth Rate" formula ("SGR"), remains, as does its two different "pathways" for physician compensation under Medicare: the Merit-Based Incentive Payment System ("MIPS") and the Advanced Alternative Payment Models ("APM"). The program is said to be designed to "reward health care providers for giving better care rather than more care." Only time will tell if it achieves this goal. While the AMA has opined MACRA will have the effect of "stabilizing" Medicare reimbursement to practitioners and will be a huge improvement over SGR, it appears this "stability" will favor large practices at the expense of solo practitioners and small groups, although the final regulations contain provisions intended to ameliorate these effects.

On May 9, 2016, the Centers for Medicare and Medicaid Services ("CMS") published proposed implementing regulations in the Federal Register. Final regulations were issued on October 14, 2016 and included some significant changes from the proposed regulations. The program was originally scheduled to go into effect in 2019, with the first "performance period" to begin on January 1, 2017. However, the final regulations have made 2017 a "transition year" and give eligible clinicians four options to choose from. Although there is a new administration in place, significant changes to the MACRA program are not expected.

This is the first in a series of revised articles setting forth what practicing physicians need to know about MACRA and its impact on Medicare reimbursement. CMS estimates that 761,342 clinicians will be eligible for MIPS, while some 30,658 – 90,000 of those clinicians could be exempt from MIPS and receive a bonus for participating in an Advanced APM. There are four options for participation in 2017; three involving MIPS and the fourth being participation in an APM.

In brief, MIPS provides a performance score based upon four factors: 1) "Quality" (replacing the Physician Quality Reporting System and Value-based Payment Modifier); 2) "Advancing Care Information" (replacing EHR Meaningful Use with meaningful use of Certified Electronic Health Record Technology ("CEHRT")); 3) "Clinical Practice Improvement;" and 4) "Resource Utilization" or "Cost Performance."

Resource Utilization will be weighted at 0% for the 2017 "transition year," but will eventually rise to 30% by MIPS payment year 2021. Based upon a composite performance score in each of these four categories, physicians will receive either a positive, or a negative, adjustment in compensation. The program is intended to be "budget neutral," so there will be equal numbers of negative and positive adjustments. Negative adjustments are capped at 4% in 2019, 5% in 2020, 7% in 2021 and 9% in 2022 and beyond, while positive adjustments must be paid out in an amount equal to the total negative payment adjustments among all providers.

Kern Augustine, P.C., Attorneys to Health Professionals, DrLaw.com, is solely devoted to the representation and defense of physicians and other health care professionals. The author may be contacted at 1-800-445-0954 or via email at Info@DrLaw.com.

KERN AUGUSTINE, P.C.

Attorneys to Health Professionals

Medicare Access and CHIP Reauthorization Act of 2015:
The Future of Medicare Reimbursement – The Merit-Based Incentive Payment System

BY:

R. Bruce Crelin
BCrelin@DrLaw.com

When the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") goes into effect, most participating physicians will fall under the Merit-Based Incentive Payment System ("MIPS"). MIPS was originally scheduled to go into effect on January 1, 2019, but its first "performance period" was to begin on January 1, 2017, as assessments in 2019 were to be based upon a two-year "look back" period; thus, payment adjustments in 2019 were to be based upon the performance factors as applied beginning in 2017. Final regulations were issued on October 14, 2016 and included some significant changes from the proposed regulations. The program was originally scheduled to go into effect in 2019, with the first "performance period" to begin on January 1, 2017. However, the final regulations have made 2017 a "transition year" and give eligible clinicians four options to choose from – three of these options involve MIPS.

There are three exceptions from participation in MIPS: 1) a physician who is participating in Medicare for the first time is exempt from MIPS for the first year of participation; 2) a physician who sees a small number of Medicare patients (100 or fewer patients) or falls below the volume threshold established for participation ($30,000 or less in Medicare Part B allowed charges); and 3) a physician who participates in an eligible Advanced Alternative Payment Model ("APM") and qualifies for incentive payments through that program (the APM exception will be discussed in a later article in this series). Estimates are that approximately 32.5% of clinicians will be exempt under the final regulations. In addition, some $100 million in technical assistance is to be made available to MIPS eligible clinicians in small practices and rural areas, and physicians should check the CMS website to see what technical assistance will be available and how to obtain access to it.

MIPS combines parts of the Physician Quality Reporting System ("PQRS"), the Value Modifier ("VM" or Value-based Payment Modifier), and the Medicare Electronic Health Record ("EHR") incentive program into a single program. Provider performance will be analyzed under four factors: 1) "Quality" (replacing the Physician Quality Reporting System ("PQRS") and Value-based Payment Modifier ("VM")); 2) "Advancing Care Information" (replacing EHR Meaningful Use with meaningful use of Certified Electronic Health Record Technology ("CEHRT")); 3) "Clinical Practice Improvement" ("CPIA"); and 4) "Resource Utilization" or "Cost Performance." Resource Utilization will be weighted at 0% for the 2017 "transition year," but will eventually rise to 30% by MIPS payment year 2021. The relative percentages will be adjusted as the program moves forward. Based upon a composite performance score in each of these four categories, physicians will receive either a positive, or a negative, adjustment in compensation.

The final regulations provide three MIPS participation options: 1) reporting for a full year; 2) reporting for a full 90-day period but for less than a full year; or 3) reporting measures in one or more Quality Performance Categories. If a clinician does nothing, the clinician will receive the full negative four percent (4%) reimbursement adjustment in 2019.

Option 1:
For full participation, a clinician must report on six quality measures, or one specialty-specific or subspecialty-specific measure set. For full participation in the Advancing Care Information Performance Category, clinicians must report on five required measures. For full participation in the Improvement Activities Performance Category, clinicians can engage in up to four activities. In addition, "exceptional performers" in MIPS are eligible for an additional positive adjustment for each of the first six years of the program.

Option 2:
Clinicians can choose to report MIPS for a period less than the full year but for a full 90-day period at a minimum and report more than one quality measure, more than one improvement activity, or more than the required measures in advancing care information (Meaningful Use of CEHRT) in order to avoid a negative payment adjustment in 2019 and possibly to receive a positive payment adjustment.

Option 3:
Clinicians can choose to report one measure in the Quality Performance Category; one activity in the Improvement Activities Performance Category; or report the required measures of the Advancing Care Information Performance Category in order to avoid a negative payment adjustment in 2019.

Third party intermediaries may submit MIPS data on behalf of an individual physician or a group practice, including:

- Qualified Registry;
- Qualified Clinical Data Registry ("QCDR");
- Health IT Vendor; and
- CMS approved survey vendors.

Physicians or medical groups who believe they may need assistance of an intermediary to submit MIPS data should start considering that NOW.

The program is intended to be "budget neutral," so there will be equal numbers of negative and positive adjustments. Both negative and positive adjustments are capped at 4% in 2019, 5% in 2020, 7% in 2021 and 9% in 2022 and beyond, while positive adjustments must be paid out in an amount equal to the total negative payment adjustments among all providers. Physicians scoring in the lowest quartile will automatically be adjusted down to the maximum penalty for the performance year. Physicians scoring at the threshold will receive no adjustment. Physicians scoring in the highest quartile are eligible for a potential positive payment adjustment up to the maximum outlined above. The highest performers will receive proportionally larger incentive payments, up to three times the maximum positive adjustment for the year.

Kern Augustine, P.C., Attorneys to Health Professionals, DrLaw.com, is solely devoted to the representation and defense of physicians and other health care professionals. The author may be contacted at 1-800-445-0954 or via email at Info@DrLaw.com.

KERN AUGUSTINE, P.C.

Attorneys to Health Professionals

Medicare Access and CHIP Reauthorization Act of 2015:
The Future of Medicare Reimbursement – The Alternative Payment Models

BY:

R. Bruce Crelin
BCrelin@DrLaw.com

When the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") goes into effect, some participating physicians will be eligible for the Advanced Alternative Payment Models ("APM"). Under MACRA, a physician who participates in an eligible APM will qualify for incentive payments through that program and be exempt from the Merit-Based Incentive Payment System ("MIPS;" discussed in the previous article in this series). The intent of the APM is to implement new payment policies which move away from fee for service.

Starting in 2019, physicians participating in a qualified APM who successfully meet the quality and performance criteria and exceed the established Medicare beneficiary thresholds will be eligible for a five percent bonus payment on their total allowed Medicare charges. APM qualifying physicians also will receive a higher Medicare physician fee schedule update (of 0.75 percent) starting in 2026. It has been said that the purpose of MIPS is to prepare practitioners to participate in Medicare via a qualified APM (pursuit of the APM pathway is valuable even if a physician falls short of the applicable criteria, as APM participation is recognized as a Clinical Practice Improvement Activity ("CPIA") under the MIPS pathway, so that efforts to participate in an APM will receive favorable scoring for the CPIA performance category in the MIPS program).

APM has been designed to facilitate new treatment delivery and payment models which move away from a fee-for-service concept, and thus most likely represents the future not only of Medicare reimbursement, but also reimbursement models which will be adopted by private health insurers as well. MACRA encourages physicians to adopt APM.

MACRA provides that qualifying APMs must be established in one of four ways: 1) through the Medicare Shared Savings Program; 2) through Centers for Medicare and Medicaid Innovation (CMMI) programs expanded by the HHS Secretary; 3) through Medicare Quality or Acute Care Episode Demonstration projects; or 4) through demonstrations required by federal law. In addition to meeting one of the four qualifying criteria set forth above, an APM must also meet established performance and quality thresholds, as follows:

- APMs must report quality and performance measures comparable to those contained in the MIPS program.
- APMs must use a certified EHR technology.

- APMs must incur nominal financial risk for monetary losses or be a medical home model expanded under CMMI authority.

Finally, in order to qualify for the five percent bonus payment, an individual physician, or a group of physicians, must show that the required percentage of payments was received through a qualified and eligible APM. As previously stated, one advantage of APM participation is that attempting to qualify as eligible to participate in an APM is recognized as a "Clinical Practice Improvement Category" under MIPS and would result in favorable scoring under that performance category under the MIPS pathway.

An Accountable Care Organization ("ACO") may qualify as an APM if it meets certain criteria. Under the proposed regulations, Medicare ACO Track 1 models would not qualify as an Advanced APM, as a Track 1 ACO does not bear risk of monetary losses as in the case of Track 2 or 3 ACOs. Under the final regulation, CMS is exploring development of the "ACO Track 1 Plus (+)" model in 2018. ACO Track 1 Model will be permitted to transition to a Track 1 Plus ACO. Track 1 Plus ACO will bear more limited risk than Track 2 or 3 ACO but have sufficient financial risk to qualify as an Advanced APM.

Look for more details from CMS in near future.

Kern Augustine, P.C., Attorneys to Health Professionals, DrLaw.com, is solely devoted to the representation and defense of physicians and other health care professionals. The author may be contacted at 1-800-445-0954 or via email at Info@DrLaw.com.