

# AMERICAN COLLEGE OF GASTROENTEROLOGY

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## MAKING \$ENSE OF MACRA

CMS...SGR... MACRA... MIPS... APMs... QCDRs... ACOs... Why does Washington D.C. love acronyms and complicated payment systems? What the heck is going on here?

### **ACG Hopes to Keep This Simple**

ACG has reviewed the law and continues to review the recently proposed regulation that implements MACRA. We compiled a detailed overview for you that seeks to make some sense out of this alphabet soup – but hopefully in a simplified fashion and in plain English. In the upcoming days, ACG will focus on certain segments of this newly proposed payment system, delving more into the specifics but in piecemeal and in brief summaries. This way, we hope the busy GI clinician is not overloaded with lengthy explanations, complicated charts, and more acronyms all at the same time.

### **Background**

On April 27, 2016, the Centers for Medicare and Medicaid Services (CMS) released the much anticipated proposed rule outlining details of how ACG members participating in Medicare will be reimbursed beginning 2019. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), enacted April 16, 2015, repealed the Medicare sustainable growth rate (SGR) formula and created a new reimbursement system beginning 2019.

This proposed rule establishes the Merit-Based Incentive Payment System (MIPS), a new program for certain Medicare-participating practitioners. This proposed rule also establishes incentives for participation in certain alternative payment models (APMs), supporting the Administration's goals of moving more fee-for-service payments into APMs.

This is a PROPOSED REGULATION and is subject to change. CMS will review stakeholder comments (due at the end on June 2016) and will likely release the final regulation in early fall of 2016.

## **MACRA: What Happens Now?**

Repealed the SGR formula last year, along with the annual ritual of looming cuts that came with it and the obligatory congressional intervention at the last minute for the temporary fix.

MACRA Update:

2016 - December 2019: A 0.5% annual update each year for Medicare fee for service providers

## **MACRA: MIPS & APMs will drive your payment update 2019 and forward**

Beginning in 2017, most physicians will be required to choose whether to be evaluated based on performance measures and activities under the Merit-based Incentive Payment System (MIPS) or to participate in an Advanced Alternative Payment Model (APM).

Beginning Jan 1, 2019- MIPS payment adjustment begins. THIS IS BASED ON YOUR 2017 REPORTING YEAR DATA.

### MIPS:

2020 – 2025: 0.0% update for fee for service

2026+: 0.25% update for fee for service

*Also Subject to Individual Provider's MIPS Score (cut, neutral payment, bonus)*

### APMs:

2019 – 2024: 5% annual update

2025: 0% APM update

2026+: 0.75% APM annual update

*Not subject to MIPS (after 2019) but Subject to APM Rules on Risk-Sharing*

**\*\* However:** Even APM clinicians must report through MIPS in the first year

# MIPS

## What the Heck is the “Merit-Based Incentive Payment System (MIPS)”?

- Consolidates current Medicare quality reporting programs: PQRS, the Value Modifier and the EHR Meaningful Use program (now called “advancing care information”) into one composite program. Adds “Clinical Practice Improvement Activities” as another category.
- Medicare will develop a “composite score” or total performance score using a scoring scale of 0 to 100. This target score will be based upon previous years’ actual composite score data or other quality reporting data if no prior year data exists (i.e. in 2019 and 2020).
- MIPS Provider will have scores for each performance category. Each category is separately weighted.
- This aggregate score will be compared to the CMS “target score.”
- The provider’s reimbursement will be adjusted (Positive, Negative, or Zero) on a sliding scale based on this targeted score vs. actual score comparison relative to all other providers.
- Please note: Providers can participate in MIPS as an individual or as part of a group practice.

## Eligibility for Merit-based Incentive Payment System (MIPS): Are all GI providers participating in Medicare assigned to this new MIPS program?

For GI, CMS estimates there are roughly 12,600 eligible clinicians in 2019 GI Clinicians that would be subject to MIPS. Who is eligible?

- Physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists

From 2021 on... Medicare has the authority to add other providers to MIPS:

- Such as physical or occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, dietitians /nutritional professionals.

## Those not Subject to MIPS

CMS estimates that there will be 1,849 GI clinicians excluded from MIPS in 2019. Who is considered ineligible?

- Newly Medicare-enrolled eligible clinicians
  - Those in FIRST year of Medicare Part B participation
- \*\*Qualifying alternative payment model (APM) Participants (QPs)
  - MACRA does NOT change how any particular APM functions or rewards value. Instead, it creates extra incentives for APM participation
- \*\*Certain Partial Qualifying APM Participants (Partial QPs)
  - A slightly reduced threshold (% of patients or payments in an Advanced APM), you are considered a “Partial Qualifying APM Participant” (Partial QP)and can opt out of MIPS to avoid a cut or participate in MIPS to potentially receive a bonus
- Clinicians who fall under the proposed low-volume threshold

- Those with less than \$10,000 in allowable claims and fewer than 100 Medicare patients would be considered low volume.

**\*\* However:** Even APM clinicians must report through MIPS in the first year

Noteworthy:

- MIPS **does not apply** to hospital reimbursement or impact ASC facility fees
- Eligible Clinicians can fulfill MIPS requirements as an individual or as part of a group (assigned by group’s TIN)
- “Virtual groups” will not be implemented in Year 1 of MIPS

**MIPS Payment Formula**

For GI, CMS estimates that roughly 62% would be eligible for a bonus and 38% would be subject to a payment cut. Thus, there must be a higher ratio of low scoring providers in other specialties.

- The BAD: The Cuts... sliding scale to maximum percent of cuts defined in MACRA:
  - 2019 -4%
  - 2020 -5%
  - 2021 -7%
  - 2022+ -9%
- The GOOD: The Bonuses... Scaling Factor up to 3x the maximum cut to determine the positive adjustment.
  - “Highest bonus cannot exceed 3x maximum penalty”
  - Subject to budget rules

Year	Maximum Cut	Bonus
2019	-4%	4% up to 12%
2020	-5%	5% up to 15%
2021	-7%	7% up to 21%
2022+	-9%	9% up to 27%

**Don't be fooled: read more on the "bonus" below**

“Exceptional Performance Bonus”: Providers in top 25% of all aggregate scores receive additional positive adjustment factor. (2019 – 2025). CMS estimates that \$13 million of this \$500 million would be for GI

- \$500 million distributed evenly each year for 6 years for these payments.
- Bonus capped at 10% per eligible provider
- Not subject to budget rules

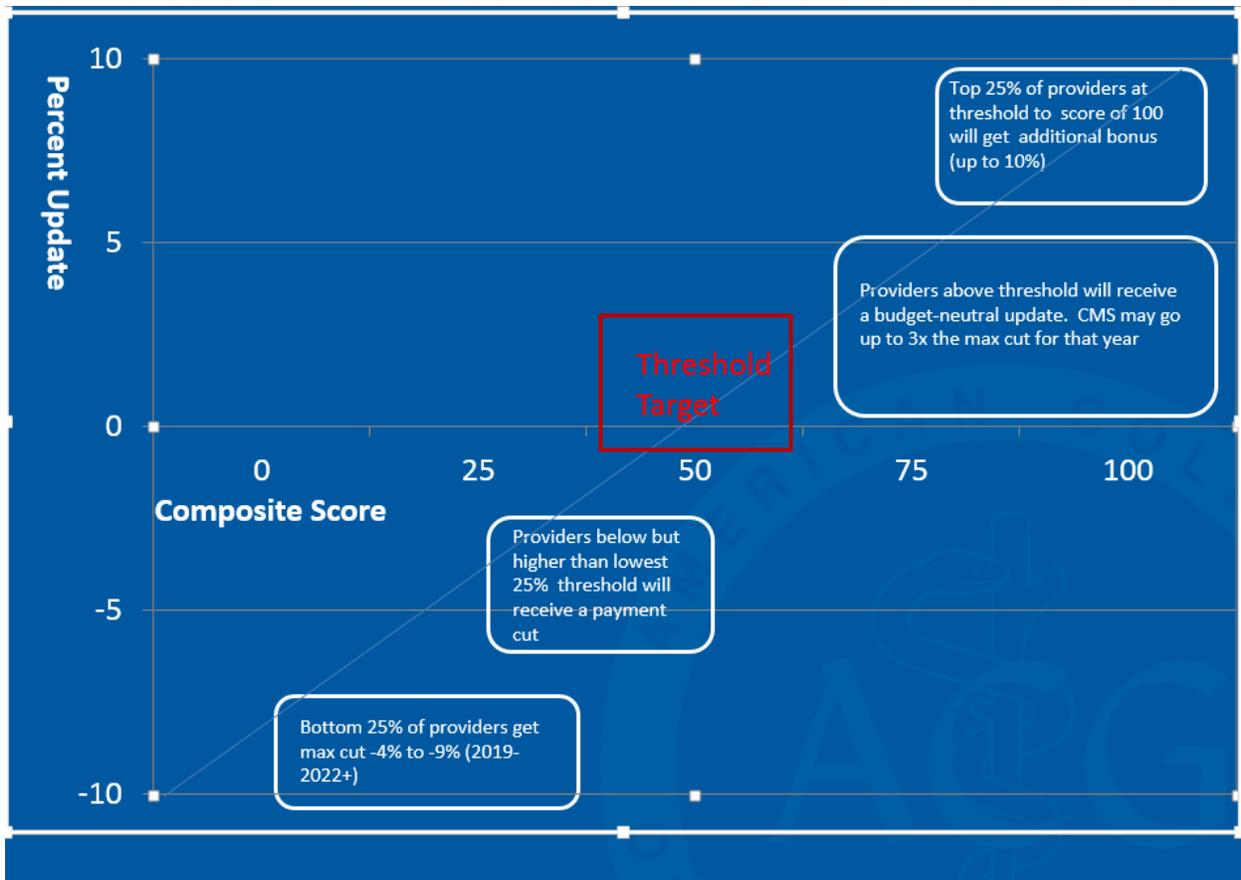
**Important note: Does that mean in 2019 the maximum penalty is 4%, but also a mean 4-12% bonus?**

- Language from MACRA: “The Secretary may adjust the positive payment percentage by a scaling factor to maintain budget neutrality but may not exceed 3X.”
- A provider could be eligible for up to a 12% bonus in 2019, but this depends on the actual maximum reimbursement cut to other providers in that particular year. It does not mean the successful MIPS scoring providers are assured a 4-12% bonus.

## Umm... Huh?

- **“Budget Neutrality”**: Bonuses are to be proportional to cuts. The total amount paid out must be equal to the total amount of penalties assessed that year for budget neutrality.
- CMS estimates that MIPS payment adjustments would be equally distributed between the cuts (\$833 million) and bonuses (\$833 million) to MIPS eligible clinicians. For GI, CMS estimates that roughly 62% would be eligible for a bonus and 38% would be subject to a payment cut.
- This means that there must be low scoring providers to have available bonuses for higher scoring providers.
- This is Medicare we are talking about here... the Merit-Based Incentive Payment System (MIPS) = “The Other Guy Must Fail First Payment System”

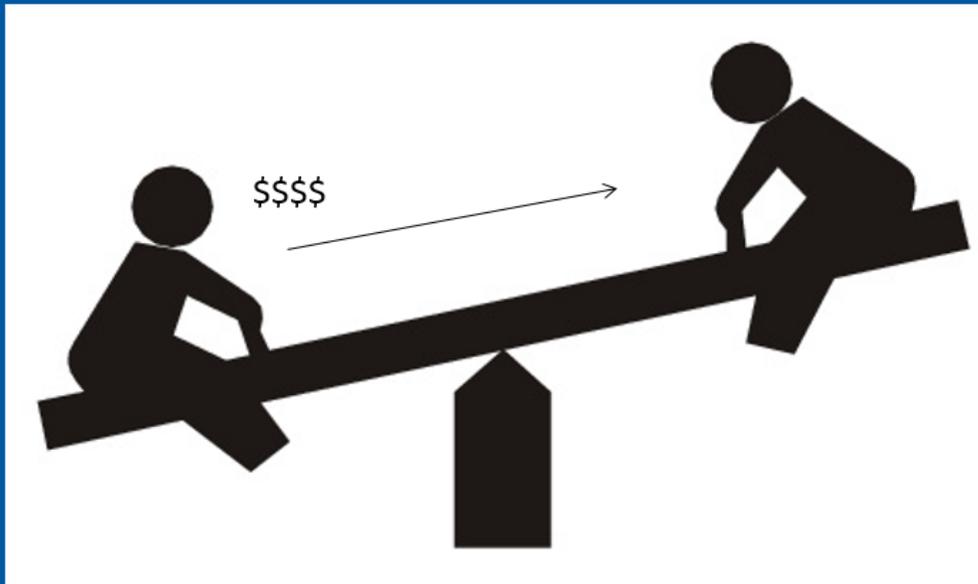
## Sounds Complicated: What Does This Look Like?



KEY TAKEAWAY: THERE MUST FIRST BE CUTS IN ORDER FOR THE POOL OF BONUS MONEY (excluding “exceptional performance” awardees)

## ~~Merit-Based Incentive Payment System (MIPS)~~

“The Other Guy Must Fail First Payment System”



## Peeling Back the Onion: More on the MIPS Performance Categories & Weights

### Weights by Performance Category

Performance Category	2019 MIPS Payment Year	2020 MIPS Payment Year	2021 MIPS Payment Year and beyond
Quality	50%	45%	30%
Resource Use	10%	15%	30%
CPIA	15%	15%	15%
Advancing Care Information*	25%	25%	25%

\*The weight for advancing care information could decrease (not below 15 percent) if Medicare estimates that the proportion of physicians who are meaningful EHR users is 75 percent or greater. The remaining weight would then be reallocated to one or more of the other performance categories.

1. **Quality:** This category is similar to the current PQRS system. Beginning 2017, CMS proposes that providers would report 6 quality measures from an annual list of available approved measures (many of which ACG members already use for PQRS now), CMS-created GI specialty measures sets, or a provider can report quality via a “qualified clinical database registry,” such as [GIQuIC](#).
  - a. Weight of 50% of total composite score in 2019
  - b. Weight of 45% of total composite score in 2020
  - c. Weight of 30% of total composite score in 2021+
  - d. Currently, providers are required to report 9 measures under PQRS— **However, CMS will automatically calculate 3 “population-based” measures in addition the 6 quality measures.**
  - e. Please note: This is a very important category to achieve a MIPS bonus, especially in the early years of MIPS (2019 and 2020)
  - f. Please note: Participation in a “qualified clinical database registry” like GIQuIC can also earn credit for other categories (more on this below)

#### Quality: Performance Requirements

CMS proposes that ACG members would select 6 measures to report, at least one of which would be a cross-cutting measure and an outcome measure (if available). Otherwise, the clinician would be required to report one other high-priority measure (i.e., appropriate use, patient safety, efficiency, patient experience, and care coordination measures) in place of an outcome measure.

- a. CMS proposes to allow registered groups of two or more MIPS eligible clinicians to voluntarily elect to participate in the CAHPS for MIPS survey. The CAHPS for MIPS survey would count as one cross-cutting and/or a patient experience measure, and the group would be required to submit at least five other measures through one other data submission mechanisms.
- b. If fewer than 6 measures apply, the clinician would be required to report on each measure that is applicable.

## Quality: Performance Requirements – Population-Based Measures

MACRA provides that the Secretary may use global measures, such as global outcome measures, and population-based measures for purposes of the quality performance category—CMS choosing to use this authority. In addition to the provider reporting 6 measures, CMS will automatically calculate “population based” measures for each provider. These calculations are derived from your Medicare claims. This will be included in the provider’s overall Quality score. These measures include: an “acute conditions” composite, a “chronic conditions” composite, and an “all cause hospital readmissions” measure.

2. **Resource Use (cost of providing care):** This category is somewhat similar to the current value-based payment modifier, where CMS looks at claims data at the practice level to determine whether group practices are cost-efficient compared to other providers. CMS would now review the individual provider’s claims.
  - a. Weight of 10% of total composite score in 2019
  - b. Weight of 15% of total composite score in 2020
  - c. Weight of 30% of total composite score in 2021+
  - d. CMS is proposing GI “episodes of care” when determining a provider’s “resource use” score relative to other providers with the same claims, triggered by claims for cholecystitis, *Clostridium difficile* colitis, diverticulitis of the colon, and/or colonoscopy with biopsy.
  - e. CMS proposes a 20 patient minimum sample for each provider and 10 points for each applicable measure. There is no maximum score as each provider’s maximum score will vary based on attributable measures and comparison to others.
  - f. A score will be calculated based on the comparison from the average or median “benchmark score” CMS calculates from the other resource measures that can be attributed to providers based on Medicare claims.
  - g. CMS: “We propose that for resource use measures, lower costs represent better performance. In other words, MIPS eligible clinicians in the top decile would have the lowest resource use.”
    - i. **Will this impact your clinical practice? For example, should ACG members think about using a “lower costing” polyp-removal techniques? Should ACG members limit the number of E&M visits that could trigger the “Clostridium difficile colitis” and “diverticulitis of the colon” episodes attributed to you?**
3. **Advancing Care Information (aka the new Meaningful Use):** This category is similar to the current Meaningful Use Program. However, CMS is attempting to reduce practice management burdens by focusing more on health IT functionality (what the EHR can do) and interoperability (who the EHR can communicate with).
  - a. Weight of 25% of total composite score
  - b. Weighting can be decreased and shifted to other categories if Sec. of HHS estimates the proportion of physicians who are meaningful EHR users is 75% or greater. There is a statutory minimum floor of 15%
  - c. No more duplicative quality reporting like providers were previously forced to do for both PQRS and Meaningful Use.

- d. No more “Clinical Decision Support” or “Computerized Provider Order Entry” objectives currently required in Meaningful Use.

.... this category is still related to Meaningful Use, so it has to be a bit more complicated, right?  
Of course. Here’s how it works:

- a. Within this category, CMS proposes a total of 131 points.
- b. First 50 points: Providers are required to report 6 objectives as a “base score” for this category: *Protect Patient Health Information* (“yes” required), *Electronic Prescribing* (numerator/denominator), *Patient Electronic Access* (numerator/denominator), *Coordination of Care Through Patient Engagement* (numerator/denominator), *Health Exchange Information* (numerator/denominator), and *Public Health and Clinical Data Registry Reporting* (“yes” required).
  - Please note that CMS proposes to place an emphasis on the *Protect Patient Health Information* objective. **Providers MUST ACHIEVE THIS OBJECTIVE TO RECEIVE ANY SCORE IN THIS CATEGORY.**
  - Please note that CMS proposes to require reporting to an immunization registry. However, a provider can receive an *additional point* by participating in a “qualified clinical database registry” like GIQuIC.
- c. Second 80 points: Providers’ numerator/denominator performance on the following 3 objectives will determine a “performance score” for this category: *Patient Electronic Access*, *Coordination of Care Through Patient Engagement*, and *Health Exchange Information*.
- d. If providers earn 100 -131 points in this category, they will receive the full 25% of the total composite score.
- e. If providers earn less than 100 points, their overall MIPS score in this category declines proportionally. Thus, this is not an “all or nothing” program or category.

**4. Clinical Practice Improvement Activities (CPIAs):** This category includes other activities focused on Expanded Practice Access, Population Management, Care Coordination, Beneficiary Engagement, Patient Safety and Practice Assessment, Participation in an APM or medical home, Achieving Health Equity, Emergency Preparedness and Response, and Integrated Behavioral and Mental Health. Providers would select from a list of 90 proposed options in the proposed regulation.

- a. Weight of 15% of total composite score.
- b. CMS proposes to update this list of approved activities annually
- c. CMS proposes to allocate a maximum of 60 points in this category and will weight certain activities higher than others. MIPS eligible clinicians or groups that select less than the designated number of CPIAs will receive partial credit.
- d. CMS proposes that highly weighted activities are worth 20 points and other activities would be worth 10 points.
- e. CMS encourages but does not require a minimum numbers of approved activities.
- f. Provider receive full credit when participating in a medical-home, and 50%+ credit for APM participation

- g. Please note: Participation in a “qualified clinical database registry” like GIQuIC can also earn credit for this category

**Was I better off in the old complicated SGR system vs. this new complicated MIPS system?**

That is to be determined. However, ACG is encouraged that CMS is at least recognizing that we must reduce these significant practice burdens in Medicare.

Important to note for solo practitioners and small practices with less than 10 providers: ACG is very concerned over the alarming burdens that CMS has estimated for solo providers and small practices. Roughly 13% of solo practitioners and 30% of small practices (2-9) would receive a bonus under the MIPS program. This is could be a significant problem for small and independent practices if the current proposals are finalized.

However, below, please find a chart on the Medicare reimbursement cuts in 2019 that outlines the outcomes if the provider chose to do nothing under the old system vs. choosing to do nothing under the new system (based on the 2017 reporting year).

	Non-Participation: MIPS	Non-Participation: Old System
2019	-4%	<ul style="list-style-type: none"> <li>• PQRs: -2%</li> <li>• Meaningful Use: -3 to -5%</li> <li>• Value-Based Purchasing Modifier**: -2% to -4% (depending on practice size)</li> </ul> <p>** Estimated. Based on CMS published data for 2017 payment year and beyond</p>
2020	-5%	<ul style="list-style-type: none"> <li>• PQRs: -2%</li> <li>• Meaningful Use: -3 to -5%</li> <li>• Value-Based Purchasing Modifier**: -2% to -4% (depending on practice size)</li> </ul> <p>** Estimated. Based on CMS published data for 2017 payment year and beyond</p>
2021	-7%	<ul style="list-style-type: none"> <li>• PQRs: -2%</li> <li>• Meaningful Use: -3 to -5%</li> <li>• Value-Based Purchasing Modifier**: -2% to -4% (depending on practice size)</li> </ul> <p>** Estimated. Based on CMS published data for 2017 payment year and beyond</p>

## APMs

### What the Heck is an “Alternative Payment Model” (APM)?

MACRA also creates an incentive program to encourage participation in “Advanced APMs” if providers do not want to participate in MIPS. CMS and Congress view the APM and transition away from fee for service and move towards the path of not only reducing programmatic costs, but also improving the quality of care for the patients.

ACG shares this goal of improved quality, but also realizes that the goal of APMs is to save money for the system or the *payor* of the health care services (insurers, Medicare); not so much to adequately reward the *payee* for providing these quality services (you).

APM participants would receive a bonus if the entity meets quality and financial goals.

### What is an example of an Advanced APM?

In this proposed regulation, CMS includes a list of payment models that would be considered an “Advanced APM.” For GI, these include:

- The Comprehensive Primary Care Plus Payment Model (CPC+)
- The Medicare Shared Savings Program (aka ACOs)- Track 2
- The Medicare Shared Savings Program (aka ACOs)- Track 3
- The Next Generation ACO Model

Each of these models have different rules but share the same basic theme: the participants share responsibility and risk in providing care to meet certain financial targets.

CMS proposes the financial risk standard for Advanced APMs in this proposed regulation: If actual APM expenditures exceed APM expected/targeted expenditures during the performance period, CMS can:

1. withhold payment for services to the APM entity and/or the APM entity’s eligible clinicians;
2. reduce payment rates to the APM entity and/or the APM entity’s eligible clinicians; or
3. require the APM entity to owe payment(s) to CMS.

### CMS proposed APM requirements:

To be an Advanced APM, an APM must meet three requirements:

(1) require participants to use certified EHR technology (50% of APM providers in first year, then 75% of APM providers);

(2) provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of MIPS (this includes a QCDR such as GIQuIC); and

(3) be either a Medical Home Model or bear more than a nominal amount of risk for monetary losses (Maximum amount of APM losses is 4% of target spending, APM responsible for up to 30% of spending above the target rate, but the APM is held harmless for anything below 4% above the target rate).

- Providers must meet Medicare payment and patient volume requirements in order to be considered Advanced APM participants: 25% of Medicare payments must go through the APM as well as 20% of the provider's Medicare patients (2019). This is increased to 75% of payments and 50% of patients by 2024+.
- Please note: CMS proposes that in order to determine whether providers met the requirements for the Advanced APM track, all providers will report through MIPS (see above) in the first year. These APM providers will also receive credit in the Clinical Practice Improvement Activity category
- Please note: APM participants falling short of APM incentive payments can choose to receive a payment adjustment through MIPS. These providers could also opt out of a MIPS payment adjustment in 2019 and 2020 if the provider had 20% of the Medicare payments through an Advanced APM and 10% of their Medicare patients through the Advanced APM.

#### **What else did CMS say about APMs?**

- CMS estimates that between approximately 30,658 and 90,000 eligible clinicians would qualify through participation in Advanced APMs, and are estimated to receive between \$146 million and \$429 million in APM Incentive Payments for CY 2019
- CMS would update this list of approved Advanced APMs each year
- In 2019 and 2020, participation for Advanced APMs are only for Medicare
- CMS anticipates in the future to approve Advanced APMs developed by commercial insurers or Medicaid programs (starting in 2021)
- The proposed rule also establishes the Physician-Focused Payment Technical Advisory Committee "to review and assess additional physician-focused payment models suggested by stakeholders"

Please note: Many ACG have questions about potential bundled payments for GI endoscopy services and other services. While there are bundled payment options for APMs, CMS did not specifically discuss bundled payments for GI at this time.

#### **Next Steps**

Stay tuned as ACG will soon have detailed information on how these proposed changes will impact GI.

[The 2016 ACG Annual Scientific Meeting and Postgraduate Course](#) will also delve into the details of these changes, as well as offer strategies and insight on how to adequately prepare your practice for these upcoming changes.