AGA REPORT

PROPOSED MEDICARE & QUALITY REFORMS

Analysis Prepared for AGA Members
May 2016
EXECUTIVE SUMMARY


There is a two-year gap between the time that reimbursement changes are applied and when services are provided — 2019 payment updates will be based on physician services provided to Medicare beneficiaries in 2017.

WHAT SHOULD I DO NOW?

For the 2016 reporting year, you should continue reporting to the Physician Quality Reporting System (PQRS), EHR Meaningful Use and the Value-based Payment Modifier. These programs form the foundation of the new Merit-based Incentive Payment System (MIPS).

MACRA’S IMPACT ON GI

• The new provisions will result in an overall positive adjustment for GIs of $34 million, which will be offset by negative adjustments for GIs totaling $16 million.

• CMS estimates that 61.5 percent of GIs will receive a positive adjustment, with 38.3 percent receiving a negative adjustment; the remaining portion will be unaffected.

• The potential for positive adjustments increases along with practice size. The practices across all specialties that are most likely to be impacted negatively are solo practices. The groups with the largest expected benefit are those with 100 or more clinicians.

CMS will accept public comments on the proposal until June 27, 2016. The final rule is expected to be issued in fall 2016; until that time, the provisions contained in the proposed rule will remain tentative. AGA will work throughout the remainder of the year to advocate for changes that represent the GI community during the rulemaking process.
KEY INFO

The MACRA proposed rule contains many improvements from existing requirements, but contains strict requirements for many activities. The rule continues a complex and difficult structure for determining physician payment based on cost and quality.

MIPS will replace existing programs and apply upward or downward reimbursement adjustments based on performance in four categories:
1. Quality.
2. Advancing care information (electronic health records).
3. Clinical performance improvement activities.
4. Resource use.

Physicians can avoid the MIPS penalties and receive a lump sum incentive payment by participating in qualified alternative payment models (APMs). However, due to CMS’ lack of GI-specific APMs at this time and the complexities of establishing an APM, these could be impractical in the first year for many smaller practices and solo practitioners.
**2017: Two Pathways for Reimbursement**

<table>
<thead>
<tr>
<th>Alternative Payment Model (APM)</th>
<th>Merit-Based Incentive Payment System (MIPS)</th>
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<tr>
<td>• Most appropriate for large systems.</td>
<td>• Most GIs will participate in MIPS.</td>
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<td>• APMs focus on care coordination, share financial risk.</td>
<td>• MIPS replaces current reporting systems.</td>
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<td>• Avoids MIPS penalties and qualifies for lump sum incentive payments by adhering to stringent standards and risk-sharing requirements.</td>
<td>• Receive bonus or penalty based on four categories:</td>
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<tr>
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<td>1. Quality</td>
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The majority of eligible clinicians (defined to include physicians and others, such as nurse practitioners, physician’s assistants, certified nursing assistants and clinical nurse specialists) will initially participate in the MIPS track. Of all eligible clinicians, CMS expects that up to 746,000 will participate in MIPS, including 12,600 GIs. However, some of these initial MIPS participants will eventually transition to APMs, which would exclude them from MIPS scoring and reimbursement adjustments.
The recent proposed rules come nearly one year after Congress’ landmark passage of MACRA legislation. The proposed rule marks the first major substantive regulatory activity to begin the transition to the new MACRA framework.

The law was created to repeal the longstanding sustainable growth rate (SGR) formula, which threatened ongoing untenable cuts to physician payment. As part of the SGR repeal, Congress mandated that CMS undertake a major overhaul of existing payment and quality programs.

The transition to a more quality and value-based Medicare program was accompanied in the law by a five-year transition period during which CMS provides stable payment updates to physicians. Once fully implemented, the new MACRA initiatives will absorb existing programs, such as EHR Incentive Program and meaningful use requirements, the Value-based Payment Modifier, and PQRS.
MIPS WORKS IN A TWO-YEAR CYCLE

Physicians and other eligible clinicians who participate in MIPS will eventually be subject to reimbursement adjustments — positive or negative — of up to 9 percent beginning in 2022 (for services provided in 2020). However, there is a transition period during which the maximum adjustment is:

- 4 percent in 2019, for services in 2017.
- 5 percent in 2020, for services in 2018.
- 7 percent in 2021, for services in 2019.

A positive aspect of the new MIPS program is that the 4 percent adjustment for 2019 is significantly less than the cumulative impact that would have faced physicians if the existing quality and EHR programs were in effect.

In addition to the general MIPS payment adjustment, CMS will award additional funds to eligible clinicians who qualify for an “exceptional performance payment” for excelling in the program.

CMS will begin by providing $500 million worth of exceptional performance payments, of which $13 million is expected to go to gastroenterology.
NOT ALL PHYSICIANS WILL BE REQUIRED TO PARTICIPATE IN MIPS

When passing MACRA, Congress required CMS to create a “low-volume threshold” below which physicians are excluded from MIPS.

The proposed rule set the threshold at fewer than 100 Medicare Part-B eligible patients and less than $10,000 billed charges for Medicare.

In addition to the low-volume exclusion, new Medicare participants will be excluded from MIPS, along with any eligible clinicians who choose to participate in an APM.

CMS expects to exclude 1,849 gastroenterology clinicians from MIPS.
MIPS REQUIREMENTS
Advancing Care Information

In order to satisfy the reporting requirement, you will be required to report on six objectives:

- Protection of patient health information.
- Patient electronic access.
- Coordination of care through patient engagement.
- Electronic prescribing.
- Health information exchange.
- Public health and clinical data registry reporting.

The remainder of your Advancing Care Information score will be based on actual performance in the categories of patient electronic access, coordination of care, and health information exchange in order to focus on patient engagement and interoperability. CMS provides sample measures that will be used in calculating the performance portion of the score, which include activities such as secure messaging, patient-generated health data and the exchange of patient care records.

Despite the potential for improvement from existing programs, the proposed rule contains some troubling requirements. CMS decided to move forward with finalizing a full-year reporting period despite ongoing objections and advocacy for a 90-day reporting period. Additionally, there is a new focus on privacy and security — if you do not satisfy the objective of protecting patient health information, you will receive no score for Advancing Care Information.
Advancing Care Information (Meaningful Use of EHRs)

MACRA provided CMS with the opportunity to overhaul the Medicare and Medicaid EHR Incentive Programs and meaningful use criteria, which provides both incentives and penalties related to EHR use.

In place of the existing programs, the new Advancing Care Information performance category will account for 25 percent of your MIPS score for 2019 reimbursement.

The proposed rule takes several steps toward addressing concerns that physician groups have voiced over the last several years, including a decrease in the total number of measures that you will be required to report. CMS also appears to have listened to provider groups that argued against the programs extreme “all or nothing” approach. Instead of penalizing providers who are unable to meet every meaningful use standard, the proposed rule implements a new structure that allows for some credit to be earned, even if not every objective is met. CMS hopes this step incentivizes continuous improvement, while taking into account the challenges faced by late adopters.

Under the new standards, satisfying the basic reporting requirement will earn you up to half of the total score that you need to earn the full 25 points for this category.
Quality Measures

As with previous reporting options, physicians can choose a specialty measure set in place of the required six measures. Those choosing to report the six measures are advised to choose at least one crosscutting measure, outcome measure or other high-quality measure. High-quality measures are related to:

- Patient outcomes.
- Appropriate use.
- Patient safety.
- Efficiency.
- Patient experience.
- Care coordination.

The proposed rule specifically points out the importance of outcomes measures compared to process measures, and notes that future rulemaking will likely place a greater emphasis on outcomes measures by increasing the quantity required.

Unlike PQRS, groups of all sizes will be subject to a mandatory reporting requirement, starting in 2017. However, the burden will be eased for population measures under the proposal. CMS will use claims data to calculate two population measures for solo practices and groups of less than 10, which eliminates the need for additional reporting requirements specifically aimed at population measures.
Quality Measures

CMS will continue to place a strong emphasis on quality of care provided to Medicare beneficiaries under the proposed rule.

The portion of MIPS scoring devoted to quality measures and performance is 50 percent, but there are several changes that could ease this part of the process for eligible clinicians.

Under MIPS, CMS reduced the number of measures that need to be reported. Unlike PQRS reporting, which remains in place for 2016 and requires nine quality measures for most physicians, the new MIPS program will only require reporting on six measures.

If the proposed rule is finalized in its current state, there will be more than 200 measures to select from, of which more than 80 percent are tailored for specialists.
Quality Measures

AGA CAN HELP

The AGA Digestive Health Recognition Program™ (DHRP) is a quality improvement program and clinical data registry that allows clinicians to demonstrate quality of care.

Qualified Clinical Data Registries (QCDR) will continue to play a role in quality reporting under MIPS. AGA’s 2016 QCDR will not only help you meet the standards established under the new MIPS, but will also meet the final year of requirements for PQRS reporting.

The 2016 AGA QCDR is different than the QCDR offered in previous years. This year, the AGA QCDR allows GIs and hepatologists to report 19 measures across several clinical topics within a single QCDR, including measures for colorectal cancer CRC screening and surveillance, HCV, and IBD, as well as your choice of several cross-cutting measures.

Learn more at www.gastro.org/DHRP.
Clinical Practice Improvement Activities

Congress specifically mandated that CMS develop a list of approved clinical practice improvement activities that will account for 15 percent of the MIPS composite score used for 2019 reimbursements. In doing so, the HHS Secretary was given great latitude to determine what satisfies the clinical practice improvement activities requirement.

The provisions of the proposed rule give MIPS participants many options for scoring well in this category. While specifics have yet to be determined, we do know that you will need to score at least 60 points, with individual activities worth either 10 or 20 points.

CMS expects to weight activities higher if they support a medical home, encourage clinical practice transformation or address public health priorities.

In order to count toward the MIPS score, a clinician will be required to perform the clinical practice improvement activities for a minimum of 90 days during the reporting period.
Clinical Practice Improvement Activities

The proposed rule provides options for meeting requirements grouped in the nine categories:

• Expanded practice access, such as same day appointments or after-hours access.

• Beneficiary engagement, including care plans for individuals with complex needs, the use of shared decision-making mechanisms, and self-management assessment and training for beneficiaries.

• Achieving health equity, such as treatment of Medicare and Medicaid dual eligible beneficiaries, accepting new Medicaid patients, participating in health insurance exchange plan networks, and maintaining equipment and accommodations for patients with disabilities.

• Population management, including participation in a QCDR, such as the AGA Digestive Health Recognition Program.

• Patient safety and practice assessment, such as the use of clinical or surgical checklists or assessments related to maintaining certification.

• Emergency preparedness and response.

• Care coordination, including timely communication of test results and exchange of clinical information to patients and other clinicians, or use of remote monitoring and telehealth.

• Participation in an APM that doesn’t fully qualify as an advanced APM.

• Integrated behavioral and mental health.

The proposed rule also notes that CMS is accepting comments on a potential new category: social and community involvement. Examples include measuring referrals to community and social services, as well as providing evidence of partnerships and collaboration with community and social services.
Resource Use

The Resource Use category of the proposed rule implements provisions of MACRA that sought to carry over requirements from the value modifier (VM) which relies on cost and quality data to measure resources used based on outcomes achieved.

The resource use category will account for 10 percent of the MIPS composite score in 2019, but increases significantly as the program progresses.

The requirements continue with the same general VM objective of rewarding clinicians who deliver more efficient and higher-quality care. The program will draw upon claims data already submitted to CMS and therefore has no additional reporting obligation.

Two key measures will be carried over from the VM – total costs per capita for all attributed beneficiaries and Medicare spending per beneficiary. This category will further assign points based on how physicians performed within separate episodes of care previously determined by CMS to be high cost, subject to high variability in resource use or for high impact conditions. CMS proposed a list of 40 episodes of care that will be used, although the proposed rule specifically states that the final rule may not contain the same number of episodes.
Resource Use

The following care episodes are proposed for gastroenterology:

- Cholecystitis.
- *Clostridium difficile* colitis.
- Diverticulitis of colon.
- Cholecystectomy and common duct exploration.
- Colonoscopy and biopsy.

Using claims data, CMS will calculate the amount of resources expended when treating the care episodes, as long as the eligible clinician meets a 20 patient minimum threshold per measure.

Eligible clinicians who do not have any resource use measures attributed to them, for reasons such as failing to meet minimum case thresholds, will not be scored on the resource use category.

In addition to the threshold exclusion, the proposed rule notes that there are no specific measures for non-patient facing clinicians and groups in 2017, so many will also be excluded from the resource use category.
ALTERNATIVE PAYMENT MODELS
ABOUT APMS

Physicians seeking to avoid potential penalties associated with the MIPS program have the option of participating in APMs, which are designed to emphasize new and innovative payment arrangements that focus on care improvement and coordination. Examples include approved medical homes and certain types of accountable care organizations (ACOs) and initiatives, such as the Comprehensive Primary Care Plus program.

Qualifying APM participants avoid MIPS penalties and will receive a 5 percent lump sum bonus in the first six years of implementation.

However, because of stringent standards and risk-sharing requirements, many smaller practices and solo practitioners will not have a viable path toward qualifying at the outset.

CMS estimates that only 30,000 to 60,000 eligible clinicians will qualify in year one, but stressed that they expect many more to qualify in later program years. If you can’t meet the standards in 2017, the option remains open in the future.
WHAT QUALIFIES AS AN APM?

Payment arrangements can qualify as an APM based on general standards related to risk-sharing, such as the amount of revenue at risk in the model or the number of patients attributed to risk.

APMs will be required to use certified EHR technology, pay based on quality measures similar to those in MIPS, and bear more than a nominal amount of risk for monetary losses. Under the proposed rule, some entities, such as medical homes and qualifying Medicare Shared Savings Program ACOs, will automatically qualify as APMs.

The decision of what other models qualify as APMs will be determined by CMS on an ongoing basis. An updated list of qualifying APMs will be provided annually.

INCENTIVE REQUIREMENTS

The proposed rule contains a long list of strict requirements for how eligible clinicians qualify for APM incentives, some of which are phased in over several years. As an example, for 2019 reimbursement, a group must have 25 percent of Medicare claims through an APM, as well as 20 percent of their Medicare patients. However, by the time the standards are fully phased in by 2024, the numbers rise to 75 percent of payments and 50 percent of patients.

CMS will also measure whether an APM includes a sufficient amount of risk based on the concept of marginal risk, a minimum loss rate and the total potential risk for which an entity could be liable under the APM.

The high bar used when determining whether an APM qualifies for the lump sum payment is expected to deter many from relying on this option.
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