American Hospital Association®

Physician Quality Payment Program

The Issue

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) changes how Medicare pays for physician services. The legislation repealed the Medicare physician sustainable growth rate (SGR) formula and instead provides predictable payment increases. The law also required the Centers for Medicare & Medicaid Services (CMS) to implement a new two-track payment system – the Quality Payment Program (QPP) – for physicians and other eligible clinicians. The QPP began on Jan. 1, 2017, and 2017 performance will impact payments in 2019.

The QPP's two tracks tie an increased percentage of physicians' Medicare fee-for-service (FFS) payments to outcomes through the new Merit-based Incentive Payment System (MIPS) as well as encourage the adoption of "alternative payment models" (APMs). APMs move payment away from fee-for-service reimbursement, and instead pay providers based on the quality and cost of care for particular episodes (e.g., bundled payment), or defined patient populations (e.g., accountable care organizations (ACOs)).

CMS laid out the initial regulatory framework for the QPP in 2016 and will finalize additional regulations by the end of this year. How CMS implements the changes contained in the MACRA will have a significant impact, not only on physicians and other clinicians, but also on the hospitals and health systems with whom they partner.

What the MACRA Does

The MACRA abolishes the SGR and from 2015 through 2025 provides physicians with a stable, sometimes flat, update to the Medicare physician fee schedule payment rates. Beginning in 2026, physicians and other health care professionals will receive different annual updates depending on whether they are paid under the new MIPS (0.25%) or primarily through advanced APMs (0.75%).

Merit-based Incentive Payment System (MIPS). The MIPS is based on the FFS model with a direct tie to quality performance. Beginning in 2019, the MIPS will be the default payment system for physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and practice groups that include these professionals. The MACRA sunsets three current-law reporting and pay-for-performance programs – the physician quality reporting system, Medicare Electronic Health Record (EHR) Incentive programs for eligible professionals, and the value-based payment modifier – and consolidates the measures and processes of these programs into the MIPS. Physicians and other eligible clinicians will be assessed in the MIPS under four performance categories:

- **Quality:** Eligible clinicians must report measures drawn from a list of over 200 measures. Multiple submission mechanisms are available, including registries, EHRs and Medicare claims.
- **Cost/Resource use:** CMS will calculate performance using risk-adjusted measures derived from claims data. The cost category does not count toward MIPS performance for 2019.
- **Improvement activities:** This category reflects participation in activities thought to improve patient safety, access to care and patient engagement. Clinicians select from a list of available activities.
- **Advancing care information (ACI):** This category is derived from current-law meaningful use requirements.

Based on their performance in these categories, physicians and eligible providers will receive a payment adjustment. The payment adjustment will be capped at +/- 4 percent in 2019, rising to +/- 9 percent in 2022 and subsequent years. In addition, for 2019 through 2024, the Secretary will designate a threshold for "exceptional performance" on the MIPS, and may spend up to $500 million each year on bonus payments to top performing providers.

Participation in Advanced APMs. The MACRA creates incentives for physicians to participate in advanced APMs, thereby moving the Medicare program away from FFS and closer to a payment system tied to patient outcomes and population health. Beginning in 2019, the APM track allows physicians receiving a significant portion of their payments through advanced APMs to be exempt from most MIPS provisions, and through 2024, to receive a lump sum payment of 5 percent of their covered services from the previous year.

To qualify as an advanced APM, a model must:

- require use of certified EHR technology;
- provide payment based on quality measures comparable to those used in the MIPS quality category; and

- bear financial risk for more than a nominal amount of monetary loss, or be a medical home that meets certain criteria. Specifically, advanced APM participants would be required to refund Medicare if their spending under the model exceeds a projected amount (known as downside risk).

APMs under Medicare include models tested by the Center for Medicare and Medicaid Innovation (including medical homes); a Medicare Shared Savings Program (MSSP) ACO; or certain other demonstrations required by federal law

Models that qualify as advanced APMs in performance year 2017 are MSSP Tracks 2 and 3, the Next Generation ACO model, the Comprehensive Primary Care Plus (CPC+) initiative, and certain tracks of the Comprehensive End-stage Renal Disease Care, Oncology Care and Comprehensive Care for Joint Replacement models.

Beginning in performance year 2019, clinicians will be able to earn incentives for combined participation in Medicare advanced APMs and "other payer advanced APMs" with non-Medicare payers (i.e., Medicare Advantage, Medicaid and private payers).

Implications for Hospitals and Health Systems

MACRA will have a significant impact on physicians, other eligible clinicians and the hospitals and health systems with whom they partner. Hospitals that employ physicians will defray some cost from implementation of and ongoing compliance with the new physician performance reporting requirements, as well as be at risk for any payment adjustments. Moreover, hospitals may participate in advanced APMs to help the physicians with whom they partner qualify for the advanced APM incentives. Finally, as a larger percentage of physician payment becomes at risk, there will likely be a continued shift in hospital-physician relationships, as hospitals and physicians seek greater collaboration on performance measurement and payment models.

AHA Position

To date, CMS's regulations continue the incremental, flexible implementation approach called for by AHA, our member hospitals, health systems and the more than 500,000 employed and contracted physicians with whom they partner to deliver care. However, significant changes must be made to policies that may impinge upon the ability of hospitals and physicians to successfully participate in the QPP. Specifically, the AHA believes the QPP should include:

- An expanded definition of advanced APMs that recognizes the substantial investments that must be made to launch and operate APM arrangements;
- A socioeconomic adjustment in the calculation of performance as needed; and
- Greater alignment between the hospital meaningful use program and the ACI category of the MIPS, and simplified ACI requirements.

The AHA is actively working with hospitals, health systems and physician groups to prepare the field for MACRA implementation. Learn more at *www.aha.org/MACRA*, which includes webinars, advisories and materials for physician and trustee education. We also welcome questions and feedback; please email *MACRA@aha.org*.

CY 2018 Proposed Rule: What We're Watching

On June 20, CMS issued proposed regulations updating QPP requirements for the 2018 performance period, which will affect payment in 2020. A final rule is due no later than Nov. 1. Below are some notable proposals for 2018.

MIPS: CMS proposes a "facility-based measurement" option that would allow for hospital-based clinicians to use their hospital's value-based purchasing program performance in the MIPS. The agency also proposes to allow clinicians and group practices of 10 or fewer clinicians to band together in "virtual groups" to participate jointly in the MIPS. CMS also would extend the use of modified stage 2 requirements for the ACI category in 2018.

Advanced APMs: CMS proposes to allow clinicians in the 2017 cohort of hospital-affiliated CPC+ practices to continue to receive credit for participation in advanced APMs, and has proposed a process for clinicians and entities participating in alternative payment arrangements with non-Medicare payers to request consideration of those arrangements as "other payer advanced APMs" beginning in performance year 2019.