MACRA 101 Primer for Psychiatrists

The Medicare program is transforming how it reimburses psychiatrists and other clinicians for providing services, under a 2015 law called the Medicare Access and CHIP Reauthorization Act (MACRA). The changes are designed to reward physicians for demonstrating a high level of quality of care or participating in new models of care that reward quality and efficiency. The Centers for Medicare and Medicaid Services (CMS) has issued the first MACRA Final Rule and regulations, published in the November 4, 2016 Federal Register. These reforms are likely to have an impact on many psychiatrists, even those who do not participate in Medicare. Other payers are looking to these policies as a model for their own reforms.

How does the MACRA stabilize Medicare payments to psychiatrists?

The MACRA repeals the flawed sustainable growth rate (SGR) formula that triggered deep cuts in payments for physician services, year after year. In its place, the law requires annual, across-the-board "updates" (increases) in Medicare Part B payments of: 0.5% per year from July 2015 through 2019; 0% (a "freeze") from 2020 through 2025; and starting in 2026, 0.75% for qualifying participants in certain alternative payment models, and 0.25% for all others. The Medicare Payment Advisory Commission will report to Congress each year on whether the update scheduled for the next year is sufficient. Then Congress can decide whether to legislate any changes.

What are the two new pathways under the MACRA?

There are two new pathways under the MACRA for psychiatrists to earn substantial rewards. First, the Merit-Based Incentive Payment System (MIPS) replaces existing Medicare quality programs and offers the first real opportunity for clinicians to receive sizable rewards for meeting quality metrics and achieving a high level of performance. Second, physicians who participate in "advanced" alternative payment models can earn a 5% bonus for each year they meet the qualifying criteria. The MACRA includes $100 million for technical assistance to small and rural practices and those in health professional shortage areas for MIPS reporting and transitioning to new models of care.

THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

The MIPS program consolidates aspects of the current Medicare quality programs, adds a new category, and offers the first substantial rewards for achieving high quality of care. The MIPS replaces Physician Quality Reporting System (PQRS), Electronic Health Records Meaningful Use (EHR MU), and the Value-Based Payment Modifier (VM), starting with 2017 reporting and 2019 payments. CMS has also made a commitment to ease physicians' administrative burden and maintain flexibility in this program.

Who are MIPS "Eligible Clinicians"?

For MIPS reporting in 2017 and 2018, "eligible clinicians" are limited to physicians, physician assistants, nurse practitioners, clinical nurse specialists, and nurse anesthetists. Starting with reporting in 2019 and payments in 2021, CMS plans to add other types on non-physician practitioners, including clinical psychologists and clinical social workers.

The MIPS program only applies to psychiatrists (and other eligible clinicians) who either participate in Medicare or have "non-participating" status in Medicare. It does not apply to psychiatrists who formally "opt out" of Medicare and are paid directly by Medicare beneficiaries under private contract.

The program covers only Medicare Part B payments for "physician services" covered by the Medicare Physician Fee Schedule. This includes separate payments to psychiatrists for seeing patients in Federally Qualified Health Centers and Rural Health Clinics, apart from the federal bundled payment. The MIPS program does not apply to Medicare Part A (hospitals, etc.); Part C (Medicare Advantage) or Part D (prescription drug plans).

What if I have few Medicare patients or just enrolled in Medicare?

Many psychiatrists will be exempt from MIPS reporting requirements and payment adjustments. The MACRA exempts clinicians from MIPS reporting requirements (and payment adjustments) if they fall below a "low-volume threshold." CMS has defined this threshold as excluding any individual psychiatrist or group practice if, during the reporting/performance year, they either: a) had Medicare Part B allowed charges less than or equal to $30,000; or b) provided care for 100 or fewer Part B-enrolled Medicare beneficiaries. The threshold was set fairly low to reduce "the risk of clinicians withdrawing as Medicare suppliers" and "mitigate an undue burden on small practices."

For 2017 reporting, CMS estimates the low-volume threshold will exclude 49% (16,521) of the 33,632 psychiatrists who see Medicare Part B beneficiaries. Another 8% (2,689 psychiatrists) are estimated to

be excluded because they just enrolled in Medicare that year. These psychiatrists can still do MIPS reporting if they want to, but they will not receive a MIPS payment adjustment.

How will I know if I'm excluded?

CMS is planning to create a "NPI level lookup feature" that will allow psychiatrists to determine if they are below the low-volume threshold and therefore excluded from MIPS. This should be ready in January 2017 or shortly thereafter. More information will be available at www.QualityPaymentProgram.cms.gov.

CMS plans to review past claims to see who falls under the threshold. For each MIPS reporting year, psychiatrists will have two 12-month time periods in which to qualify. They can be excluded if their Medicare Part B allowed charges or beneficiaries meet the low-volume threshold in either (or both) of these periods. For the 2017 reporting year, these two qualifying periods are from September 2015 through August 2016, or September 2016 through August 2017.

The low-volume analysis will be calculated separately at the individual NPI (National Provider Identifier) level, and then also at the group TIN (Tax Identification Number) level, depending on how each psychiatrist is paid. Those who are paid through both their NPI and one or more TINs may be excluded with respect to their NPI billings, but not with respect to the TIN(s). This may be true for many psychiatrists, as groups are subject to the same standards as individual practices – no more than $30,000 in Part B allowed charges and no more than 100 beneficiaries enrolled in Part B.

MIPS REPORTING AND ADJUSTMENTS

The basic MIPS annual bonuses and penalties will be up to 4% in 2019, 5% in 2020, 7% in 2021, and 9% starting in 2022. These are calculated for each eligible clinician (or group) and occur as an addition or reduction to their Medicare Part B payments. These are budget-neutral, so individual bonuses will be "scaled" so the totals of all bonuses and penalties are roughly equal. The penalties cannot go above the annual ceiling for that year. There is an additional, separate bonus from 2019 through 2024, for "exceptional performers" whose performance is scored in the top sector (usually the top 25%). This bonus can be up to an extra 10%, for up to a total of $500 million per year.

What is "Pick Your Pace" reporting for 2017?

MIPS reporting begins in 2017, with payment adjustments starting in January 2019. Generally, the MIPS reporting (and performance) period will be the full calendar year 2 years prior to the year of payment adjustments. However, for 2017, the first reporting year, CMS is allowing clinicians more time to transition to the MIPS program by adopting relaxed requirements known as the "Pick Your Pace" approach. This approach offers five options for 2017 reporting:

1. Avoid the 4% MIPS penalty by reporting one quality measure, one improvement activity, or all the Advancing Care Information base score measures for part of 2017;
2. Possibly earn a "small" bonus by reporting complete MIPS data for at least 90 days;
3. Possibly earn a "modest" bonus by reporting complete MIPS data for the whole year;
4. Earn a MIPS exemption by meeting the definition of a "Qualifying Participant" or "Partially Qualifying Participant" in an "Advanced Alternative Payment Model"; or
5. Not report at all, and receive the full 4% MIPS penalty.

What goes into my MIPS Composite Score?

Each eligible clinician or group – not excluded from MIPS reporting – will receive a MIPS Composite Score that will determine their MIPS adjustment for that year. They will be compared to a "performance threshold" for that year, based on the average performance of all eligible clinicians from a prior period. Scoring above performance threshold results in a bonus/positive adjustment; scoring below it yields a penalty/negative adjustment. There is no adjustment if you score at the threshold.

The Composite Score is made up of individual scores for four different performance categories. There is some flexibility in how these are weighted, but they generally count as described below. More detailed information is provided in the separate APA Fact Sheets for each category.

MIPS Quality Performance Category: Quality counts 60% for the 2017 reporting year (and 2019 adjustments); 50% for 2018 reporting (and 2020 adjustments); and 30% starting with 2019 reporting (and 2021 adjustments). This category builds on the Physician Quality Reporting System (PQRS), but has more reasonable reporting standards. PQRS required the reporting of nine quality measures across three National Quality Strategy "domains." The MIPS requirement is to report six quality measures, including one outcome measure is one is available – or one measure of appropriate use, patient safety, efficiency, patient experience, or care coordination. The MIPS continues most valid PQRS quality measures and add measures used by private payers and for different settings. There is a "Mental /

Behavioral Health" measure set with 12 measures relevant to psychiatrists. The MACRA also includes $75 million to fund development of new quality measures.

MIPS Cost Performance Category: Cost counts 30% starting with reporting in 2019. But for the 2017 reporting period, it will not be counted in your MIPS score. It will count 10% for 2018 reporting. There is no specific reporting for this category, it will be calculated by CMS. The Cost category replaces the Value-Based Payment Modifier (VM). Starting in 2018, all Medicare claims will include special codes indicating the correct care episode, patient condition, and physician's relationship to the patient. These codes, which are still being developed, will help link patients to the right clinicians for measuring the MIPS Cost score. Psychiatrists should also be aware that in 2017 and 2018, Medicare Part B payments to all psychiatrists (regardless of practice size) will be subject to VM bonuses or penalties. These currently range up to 2% for small practices (up to 10 physicians) and up to 4% (for larger practices). Many physicians were considered "average" and did not receive any adjustment.

MIPS Advancing Care Information (ACI) Performance Category: This category counts 25% and replaces the EHR Meaningful Use (MU) program. In order to pass this category, a psychiatrist must either use certified electronic health record technology (CEHRT) or qualify for a hardship exemption. Hardships include: a) insufficient internet connectivity; b) extreme and uncontrollable circumstances (such as natural disasters); c) lack of control over availability of CEHRT (including practicing in multiple sites or where there was no input in the selection of technology); and d) lack of face-to-face interaction (telepsychiatry is considered face-to-face). The ACI category retains some measures from the MU program, eliminates others, and replaces the MU "all or nothing" approach with incremental credit for various activities. Psychiatrists must report five measures to achieve a Base Score. Then they can earn points for reporting up to eight measures for their Performance Score. Bonus points are also given for certain activities.

MIPS Improvement Activities (IA) Performance Category: This is a new category, which counts 15%. There are 93 activities for 2017 reporting, including eight "Integrated Behavioral and Mental Health" activities such as collaborative care and participation in the Transforming Clinical Practice Initiative (in which the APA is a participant). The maximum IA score is 100. Forty points are usually required to achieve full credit, with high-weighted activities counting 20 points each, and medium-weighted activities counting 10 points. The requirements are lower for small and rural practices and those in health professional shortage areas. Participation in certain alternative models of care, such as

medical homes and accountable care organizations, can earn half or even full credit in this category.

What are the MIPS reporting methods and options?

The MIPS program preserves the current reporting methods of the previous Medicare quality programs. These include qualified clinical data registries (QCDRs), qualified registries, electronic health records, claims (for Quality) and administrative claims/no submission required (for Quality and Cost). Attestation is another method, for the IA and ACI categories. Groups of 25 or more may also use the CMS Web Interface. Vendors approved by CMS would report the CAHPS for MIPS patient surveys.

The MACRA encourages reporting via QCDRs by individuals and group practices. In addition to being less burdensome, registry reporting can earn credit under the ACI and IA categories, potentially leading to higher MIPS scores and bonuses. QCDR measures can also be directly approved by CMS, which avoids the lengthy, complex review process for approval by the National Quality Forum. The APA is now developing a mental health clinical quality data registry for use by psychiatrists in quality reporting.

"Virtual Group" Reporting: The MACRA allows small practices (of up to 10 MIPS eligible clinicians) to form a voluntary "virtual group" for the purposes of MIPS reporting and assessment. That group can submit their MIPS data together, and their performance will be assessed as a group. This can allow small practices to pool resources and invest in whatever support they need. This option will be available starting with 2018 reporting. CMS plans to develop a web-based registration process to register each virtual group, and to discuss its plans in next year's MACRA proposed rule.

INCENTIVES FOR "ADVANCED" ALTERNATIVE PAYMENT MODELS

Psychiatrists, other physicians, and non-physician practitioners may qualify for Medicare payment incentives for participating in new models of care and delivery that improve quality, lower health care spending, or both.

Some may be eligible for 5% incentive payments, from 2019 through 2024, if they have sufficient revenue or patients tied to these new models of care – they would be considered a "Qualifying Participant" in an "Advanced" Alternative Payment Model (APM). They are also exempt from the MIPS program and will receive slightly higher annual payment increases starting in 2026.

Those with slightly lower levels of revenue or patients tied to Advanced APMs may be considered "Partially Qualifying Participants." They can elect not to do MIPS reporting, and not incur a penalty.

To be considered an Advanced APM, a model must be approved by CMS and meet four criteria:

1. It must be approved by the CMS Innovation Center, part of the Medicare Shared Savings Program, or a certain type of federal demonstration program.
2. It must require at least 50% of its participants to use certified electronic health record technology (CEHRT). Any hospital within the APM must also use CEHRT.
3. It must tie at least some payments to performance on one or more quality measures comparable to those under the MIPS program, including one outcome measure.
4. It must accept financial risk, i.e., suffer financial consequences for failing to meet cost and/or quality metrics. These could be lower payments, deductions, or repayments.

CMS has approved the following models as Advanced APMs for the 2017 participation year and incentives in 2019: a) Medicare Shared Savings Program Accountable Care Organizations (ACOs) - Tracks 2 and 3; b) Next Generation ACO Model; c) Comprehensive Primary Care Plus (CPC+); d) Comprehensive End-Stage Renal Disease (ESRD) Care Model; and 3) Oncology Care Model - Two-sided risk arrangement.

In 2018, CMS plans to add the following models as Advanced APMs: a) Medicare Shared Savings Program ACOs - Track 1+ (with less risk than Tracks 2 or 3); b) New Voluntary Bundled Payment Model; c) Comprehensive Care for Joint Replacement Payment Model - CEHRT track; and d) Advancing Care Coordination through Episode Payment Models (Cardiac and Joint Care) - Track 1 (CEHRT track).

There is currently no Advanced APM strictly for mental health or substance abuse. The Physician-Focused Payment Model Technical Advisory Panel (PTAC) will assist physicians and other clinicians in developing APMs. The APA will be advocating for psychiatrists to get credit for their current efforts, as well as exploring new opportunities for models in which psychiatrists may participate.

OTHER MACRA PROVISIONS

The MACRA also extended funding for many federal health programs, including the Children's Health Insurance Program (CHIP), Medicare Advantage special needs plans, and the Medicare-dependent hospital program. It also codified into law new policies which: a) allow psychiatrists (and other clinicians) to choose to "opt out" of Medicare indefinitely, so they no longer have to renew their status (or submit affidavits) every two years; b) prevent quality programs standards (such as PQRS or MIPS)

from being used as a “standard of care” in medical liability lawsuits; c) raise Medicare premiums for high-income beneficiaries in later years; and d) made permanent the Medicaid qualifying individual and transitional medical assistance programs for low-income patients.

RESOURCES

Where can I find other APA resources?

Additional APA resources, including more detailed Fact Sheets on each of the MIPS Performance Categories plus Advanced Alternative Payment Models, are available at psychiatry.org/PaymentReform.

What should I do if I have questions or issues?

APA members may submit questions by email to APA staff at: qualityandpayment@psych.org.

What other resources are available?

- MACRA Final Rule (Nov. 4 Federal Register):

https://www.gpo.gov/fdsys/pkg/FR-2016-11-04/pdf/2016-25240.pdf

- CMS Fact Sheet (12 pages): https://qpp.cms.gov/docs/Quality_Payment_Program_Overview_Fact_Sheet.pdf
- CMS Executive Summary (24 pages): https://qpp.cms.gov/docs/QPP_Executive_Summary_of_Final_Rule.pdf
- CMS Quality Payment Program Website: https://qpp.cms.gov/