



All Tribes Call: CMS MACRA Quality Payment Program (MIPS and APMs)

Memorandum

May 19, 2016

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Overview:

- On April 27, 2016 CMS released the proposed rule for the *Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models*, also named the Quality Payment Program.
- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repeals the Medicare sustainable growth rate (SGR) methodology for updates to the physician fee schedule (PFS) and it replaces it with a new Merit-based Incentive Payment System (MIPS) for eligible clinicians and other groups under the Physician Fee Schedule (PFS). The proposed rule would also establish incentives for participation in Alternative Payment Models (APMs).
- MIPS would streamline and consolidate components of three existing programs, the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals (EPs). MIPS would continue to focus on quality, resource use, clinical practice improvement, and advancing care information through the use of certified EHR technology (CEHRT) without redundancies.
- Timeline: By November 1, 2016 – MACRA final rule will be published (mandated by the MACRA legislation) and the first MIPS performance year begins on January 1, 2017.
- The current quality and value reporting programs (PQRS, VM, and EHR) will sunset at the end of 2018 and MIPS will begin adjusting payment in calendar year 2019. The performance period is calendar year 2017 for payment year 2019.
- MIPS eligibility for calendar year 2017 and 2018 performance years include: Physicians (MD/DO and DMD/DDS), Physician Assistants, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists. Eligibility for calendar year 2019 and beyond performance years expand to: physical and occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, and dietitians/nutritional professionals
- Comments should be submitted by June 27 (refer to file code CMS-5517-P). They can be submitted here: <https://www.regulations.gov/#!documentDetail;D=CMS-2016-0060-0068>.
- Contact Sarah Freeman, NIHB Policy Associate at sfreeman@nihb.org to join the Medicare, Medicaid, and Health Reform Policy Committee (MMPC) MACRA Quality Payment Program Workgroup for open Tribal discussions around the proposed rule as well as to receive a template comment.

QUESTIONS

- Can you explain in short answer the difference between MIPS and APMs?

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- Do any Tribes operate Accountable Care Organizations (ACOs)?
- In a nutshell, how would this rule impact I/T/U's?
- How are FQHCs impacted by MACRA (MIPS)? How would Accountable Care Organizations (ACOs) be impacted?
- Is there anything I/T/Us are doing that could qualify us as an APM?
- What are the 2015 measures under consideration for MIPS in terms of primary care?
- What structure/ processes are set up (foundation) for reporting?
- Can CMS use an I/T/U as a test site?
- What is the preferred workflow for reporting I/T/U provider performance and how will CMS approach reporting?
- Does CMS have an implementation plan?
- Currently, clinics get an all-inclusive rate. Will they get an all-inclusive rate with MACRA?
- From a reimbursement perspective would I/T/Us be risking anything using the APM processes?
- If you have received penalties with the current PQRS system, will you continue receiving these penalties?
- What about the inclusion of Marriage Family Therapists (MFTs) in the Behavioral Health reference to social workers?

POTENTIAL CONCERNS

- Doctors may not be ready for implementation in 2017. Simply identifying appropriate measures is challenging and there are only months between now and when the rule is implemented to prepare physicians.
- **Unsustainable for Small and Rural Practices:** APMs will be difficult for providers and nursing homes that are not part of larger health systems and do not have the experience or infrastructure for creating them.
- **Telemedicine in MACRA:** Telemedicine should be used as a key resource to increase access to health care for American Indians and Alaska Natives, especially due to the geographic location of Tribes. Some industry advocates are upset that CMS barely nodded to telemedicine in last month's MACRA rules on clinical practice improvement activities. Only two of the ninety ways CMS lists as counting toward improved care involve telemedicine, although Congress, in the MACRA law, directed the agency to consider telemedicine and remote monitoring as qualifying.
- **Long Term Care and End of Life Care Patient Concerns:** The elderly population is often disregarded in efforts of payment reform, even though 25% of traditional Medicare healthcare spending occurs in the last year of life for beneficiaries 65 and older. Quality metrics do not reflect what is often the best course of treatment for the elderly and those with chronic diseases (ex. Screenings).