MACRA
Piecing Together Your Options

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The clock is ticking for implementation of the new Medicare value-based payment program. On October 14, 2016, the Centers for Medicare and Medicaid Services (CMS) released its highly anticipated Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models final rule with comment period. The rule finalizes parameters for participation in MIPS and APMs, collectively known as the Quality Payment Program (QPP), which went into effect January 1, 2017. According to CMS, the strategies within the final rule are based on more than 4,000 written comments and interaction with more than 100,000 physicians and stakeholders during outreach sessions.

The common theme throughout the final rule is flexibility, at least for the first year of the program, in an effort to alleviate provider concerns and encourage participation during the transition year. CMS anticipates the QPP to evolve over the next several years as it moves toward a more value-based, outcomes-focused and patient-centered program.

Background: MACRA Refresher
The Medicare Access and Children’s Health Insurance Program Reauthorization Act of 2015 (MACRA) was signed into law on April 16, 2015 by former President Barack Obama, ending the 13-year struggle to fix the seriously flawed Sustainable Growth Rate (SGR) formula. The SGR was a methodology used by CMS to control Medicare spending so that the yearly increase in the expense per Medicare beneficiary did not exceed gross domestic product (GDP) growth. As Medicare spending grew, however, necessary payment adjustments to reduce expenditures in the SGR formula were never implemented. Therefore, to avoid significant cuts to physician payments each year, Congress passed temporary patches known as the “doc fix.” Seventeen patches were passed over a 13-year period. MACRA repealed the SGR methodology and averted the 21% Medicare payment cut that was scheduled for 2015. In its place, the QPP program will now offer two tracks for earning additional Medicare payment.

Political Impact on MACRA Implementation
While health care could be impacted during Donald Trump’s presidency, it is speculated that MACRA won’t see significant changes. It is important to note that
MACRA and the Affordable Care Act, or ObamaCare, are two separate pieces of legislation. The MACRA legislation was passed easily by both the House and Senate, with support from a whopping 91% of Congress, or 484 congressional members. Efforts to overturn the bipartisan legislation would likely have little success given the high approval rating. The shift toward value-based care has been decades in the making, and both parties agreed that MACRA should be the path for value-based care. While evolution of MACRA is expected, repeal is not. Therefore, eligible clinicians are encouraged to start implementing components required by MACRA now to avoid future negative payment updates to Medicare payments.

How Do I Participate?
Two Payment Tracks Options
Under the QPP, eligible clinicians have the option to choose from two new payment track options for earning additional Medicare payment, either by participating in MIPS or an eligible Advanced APM. MIPS consolidates components from existing Medicare quality reporting programs, including the Physician Quality Reporting System (PQRS), the Value Modifier (VM) Program, and the Electronic Health Record (EHR) Incentive Program/meaningful Use, into a single program with four weighted performance categories. An APM is a payment approach, developed in partnership with the clinician community that can be applied to a specific clinical condition, care episode or a population, and provides added incentives to clinicians to provide high quality and cost-efficient care. Depending on the track you choose in 2017, your 2019 Medicare payments will be adjusted up, down or not at all.

Track 1—MIPS
Eligibility: Who’s in?
For 2017, you are considered eligible to participate in the MIPS track if you bill more than $30,000 annually to Medicare, provide care to more than 100 Medicare patients per year, and you are one of the following eligible clinicians:

- Physicians (MD, DO, DPM, DDS, OD, DC)
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Nurse anesthetists
- Group practices with these providers

Eligible clinicians can participate in MIPS as individuals or in a group practice. An individual is defined as a single National Provider Identifier (NPI) tied to a single Tax Identification Number (TIN). A group practice is defined as a set of clinicians sharing a common TIN, no matter the specialty or practice site. Eligible clinicians who choose to report as an individual or as a group practice must consistently report (as an individual or group) across all MIPS categories.

Who’s Out?
The following Medicare providers are excluded from the MIPS program if they meet one of the following criteria:

- Are enrolled in Medicare Part B for the first time during a performance year
- Meet low-volume threshold criteria

*Medicare Part B allowed charges are less than or equal to $30,000; OR
*Bill for 100 or fewer Medicare Part B patients
- Participate in a qualified Advanced APM

What are the requirements?
MIPS participants will be assessed on four performance categories:

- Quality
- Improvement activities
- Advancing care information
- Cost

MIPS reporting requirements for 2017 are outlined in Table 1. It should be noted that CMS is also offering a flexible track option for avoiding negative payment adjustments for the first year of the program and this is also discussed below.

Pick your pace: Flexibility for the transition year
For the first year of the program, CMS is offering a flexible participation track to accommodate those eligible clinicians who are not ready to fully participate in MIPS in 2017 (Figure 1). This allows eligible clinicians to submit just one measure or one improvement activity and still avoid the negative payment adjustment.

Eligible clinicians can choose their course of participation in MIPS with the following options:

1. Clinicians can choose to report one measure in the quality performance category, one activity in the improvement activities performance category, or report the required measures of the advancing care information performance category and avoid a negative MIPS payment adjustment. Alternatively, if MIPS eligible clinicians choose to not report even one measure or activity, they will receive the full negative 4% adjustment.

2. Clinicians can choose to report to MIPS for a period of time less than the full year performance period 2017; however, a 90-day period is the minimum. To avoid a negative MIPS payment adjustment and to possibly receive a positive MIPS payment adjustment, clinicians can report:

   - More than one quality measure
   - More than one improvement activity
   - More than the required measures in the advancing care information performance category

3. Clinicians can choose to report to MIPS for a full 90-day period or the full year to maximize the MIPS eligible clinician’s chances to qualify for a positive adjustment. In addition, MIPS eligible clinicians who submitted practice information shows they are excellent performers, are eligible for an additional positive adjustment for each year of the first six years of the program. Clinicians who achieve
Table 1. 2017 MIPS Program Requirements

<table>
<thead>
<tr>
<th>Category</th>
<th>What is it?</th>
<th>What are the requirements?</th>
<th>2017 category weight</th>
<th>How do I participate?</th>
</tr>
</thead>
</table>
| Quality               | Replaces the Physician Quality Reporting System (PQRS)                      | The following requirement applies to most eligible clinicians and group practices:  
• Report six quality measures, one of which must be an outcome measure, or if no outcome measures are available, one must be a high priority measure  
OR  
• Report one specialty specific measure set  
The following requirement applies to group practices reporting via the web interface:  
• Report 15 quality measures for a full year | 60%                 | The list of available quality measures can be viewed at: https://qpp.cms.gov/measures/quality.                                                                                           |
| Improvement Activities| New category—This category awards clinicians for participating in activities in the following areas:  
• Achieving health equity  
• Behavioral and mental health  
• Beneficiary engagement  
• Care coordination  
• Emergency response and preparedness  
• Expanded practice access  
• Patient safety and practice assessment  
• Population management | In the final rule, CMS finalized Improvement Activity weights as medium (10 points per activity) or high (20 points per activity)  
The following requirement applies to most eligible clinicians and group practices:  
• Attest that you completed two high weighted improvement activities for a minimum of 90 days OR four medium weighted activities for a minimum of 90 days; OR a combination of high and medium weighted activities to achieve the highest possible score of 40 points for a minimum of 90 days  
The following requirement applies to group practices with fewer than 15 participants or if you are in a rural or health professional shortage area:  
• Attest that you completed one high weighted improvement activity for a minimum of 90 days OR two medium weighted activities for a minimum of 90 days | 15%                 | The list of eligible improvement activities can be viewed at: https://qpp.cms.gov/measures/ia.                                                                                                     |
| Advancing Care Information | Replaces the EHR Incentive Program/ Meaningful Use | Eligible clinicians must report on the following required measures for a minimum of 90 days:  
• Security Risk Analysis  
• e-Prescribing  
• Provide Patient Access  
• Send Summary of Care  
• Request/Accept Summary of Care  
PLUS  
• Choose to submit up to nine measures for a minimum of 90 days for additional credit  
For bonus credit  
• Report Public Health and Clinical Data Registry Reporting measures  
• Use certified EHR technology to complete certain improvement activities in the improvement activities performance category  
OR  
• You may not need to submit advancing care information if these measures do not apply to you | 25%                 | Options for reporting and submitting your data can be viewed at: https://qpp.cms.gov/measures/aci.                                                                                             |
| Cost                  | Replaces Value-Based Payment Modifier                                      | Data submission is not required. Category will be calculated from adjudicated claims.                                                                                                                                                                                                                                                                                                                                                                                                                      | 0%; will be weighted in future years | N/A                                                                                                                                                                                                                                                                         |
a final score of 70 or higher will be eligible for the exceptional performance adjustment, funded from a pool of $500 million.\(^1\)

**How Is MIPS Performance Calculated?**
First, each of the four categories will receive an individual performance score. An overall composite score will then be assigned based on the summed performance in all categories. The final score is the sum of each of the products of each performance category score and each performance category’s assigned weight, multiplied by 100. The final rule outlines methodology for calculating performance scores for each category. If a MIPS eligible clinician or group believes their MIPS score has been unfairly calculated, they have a 60-day period to submit a request for a “targeted review” or appeal to CMS.

For payment year 2019, based on performance in 2017, CMS assigned the following weights to performance categories (Figure 2):
- Quality: 60%
- Improvement Activities: 15%
- Advancing Care Information: 25%
- Cost: 0%

For the first year of MIPS, CMS will not be assigning weight to the Cost category. However, by payment year 2021, it is anticipated to increase to 30%. To accommodate the increasing cost threshold, weights in the other categories will decrease.

**What are the Bonuses and Penalties?**
- Payment Year 2019: Maximum penalties and bonuses are 4%.
- Payment Year 2020: Maximum penalties and bonuses are 5%.
- Payment Year 2021: Maximum penalties and bonuses are 7%.
- Payment Year 2022 and beyond: Maximum penalties and bonuses are 9%.

Since MIPS is a budget neutral program, bonuses and penalties must balance. For years 2019 to 2024, eligible clinicians whose composite scores fall above the threshold may be eligible for additional bonuses of up to three times the payment adjustment amount for each payment year (Figure 3). Additional money is also available to eligible clinicians who fall in the “exceptional performance” category. MACRA legislation defines an “exceptional performance” bonus pool of up to $500 million per payment year from 2019 to 2024 to be awarded to the eligible clinicians who receive the highest scores.

**Track 2—Alternative Payment Models**
Track two, or participation in an alternative payment model (APM), centers on incentivizing providers based on quality metrics, outcomes and cost efficiency. As discussed earlier in this article, HHS has set explicit goals for tying participation in eligible APMs...
to payment and CMS will provide increased fee schedule payment updates for qualifying APM participants to incentivize this transition. Compared with the proposed rule, CMS made several changes related to APM participation in the MACRA final rule.

When deciding whether to participate in an APM, however, it is important to consider that participation in an APM comes with some level of financial risk—APMs are essentially shared risk-based payment models. Consider these two examples:

1. In an upside risk arrangement, providers share in cost savings if the cost of care stays below the target budget.
2. In a downside risk arrangement, providers share in financial losses if costs exceed the predetermined budget.

How Is APM Defined?
MACRA defines any of the following as an APM:

- An innovative payment model expanded under the Center for Medicare & Medicaid Innovation (CMMI) or another payer, including Comprehensive Primary Care (CPC) initiative participants, but not Health Care Innovation Award recipients
- A Medicare Shared Savings Program accountable care organization (ACO)
- Medicare Health Care Quality Demonstration Program or Medicare Acute Care Episode Demonstration Program, or another demonstration program required by federal law

What Are Examples of APMs?

- ACOs are collections of health care organizations that contract with CMS for management of group beneficiaries with shared savings and risks. Initial contracts include one-sided share in savings only or two-sided share in savings and risks.
- Episodes of care and bundled payments set a predetermined budget for a patient’s total care for a specific condition. Different retrospective payment models include inpatient DRG treatment payment only, inpatient plus post discharge treatment periods and only post acute care service payment models. Payments are based on fee-for-service with reconciliation based on established payment rates. The prospective payment model of single payment to a hospital with funds distributed by the hospital to the providers for inpatient and post readmission periods is also available. An example is major joint replacement, which had significant savings by transferring patients in the post acute care period from inpatient rehabilitation to skilled nursing or home health care.
- Condition-specific population models such as Million Hearts (cardiovascular reduction model), comprehensive end stage renal disease care initiative and oncology care models are available. To date, no spine-specific model is available.
- Comprehensive primary care initiatives such as primary care medical homes are also available.
- Physician-focused payment models as outlined by AMA are concepts in progress and addressed below.

MACRA established the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review and assess payment models submitted by stakeholders to increase the number of qualifying models.

Physician-Focused Payment Models (PFPMs)
The MACRA final rule expanded the definition of PFPM to include practitioners other than physicians. Payment models can target the quality and costs of services that other practitioners provide, order, or significantly influence, rather than just physician services.

Advanced APMs
Advanced APMs are a subset of APMs that require additional risks and requirements. To qualify as an advanced APM, the following requirements must be met:

- participants must use certified EHR technology (CEHRT);
- payment within APM must be based on quality measures similar to MIPS;
- APM entities must bear monetary risk more than nominal amount or be a medical home model.

CMS will release a list of qualifying advanced APMs in early 2017. Currently, the following models qualify as advanced APMs:

- Comprehensive End Stage Renal Disease Care Model (Two-Sided Risk Arrangements)
- Shared Savings Program Track 2
- Next Generation ACO Model
Comprehensive Primary Care Plus
Shared Savings Program Track 3
Oncology Care Model (Two-Sided Risk Arrangement)
Incentives for Participation

Beginning in 2019, if an eligible clinician participates in an Advanced APM, that clinician may become a Qualifying Participant (QP). Eligible clinicians who become QPs are excluded from MIPS.

For years 2019 through 2024, QPs receive a lump sum incentive payment equal to 5% of their prior year’s payments for Part B covered professional services. Beginning in 2026, QPs receive a higher update under the PFS than non-QPs.

For 2019 and 2020, eligible clinicians may become QPs only through participation in Advanced APMs. For 2021 and later, eligible clinicians may become QPs through a combination of participation in Advanced APMs and Other Payer Advanced APMs.

What Is an APM QP?

- Clinicians who have a certain percentage of Medicare Part B payments for professional services or patients furnished Part B professional services through an Advanced APM Entity. (Table 2)
- Beginning in 2021, the threshold may be reached through a combination of Medicare and other non-Medicare payer arrangements, such as private payers and Medicaid.
- The QP performance period for each payment year will be from January 1-August 31 of the calendar year two years prior to the payment year.

How do Eligible APMs Qualify for Bonus Payments?

To qualify for bonus payments, eligible providers must meet increasing thresholds for the percentage of revenue they receive through eligible APMs.

Partial Qualifying APM Participants (Partial QPs)

Clinicians who participate in Advanced APMs, but do not meet the threshold, may become partial qualifying APM participations and may choose whether to participate in MIPS. (Table 3)

Partial QPs would not be eligible for the 5% incentive payment or the APM conversion factor, but can decide whether to be subject to the MIPS payment adjustment.

Once the Advanced APM entity has determined that they are partial QPs, the entire group will decide whether to participate in MIPS. If they elect to not participate, then all clinicians in the group will be excluded from MIPS payment adjustments.

CMS will provide updates on qualifying status at three points during the performance period.

### Table 2. Requirements for Incentive Payments in Advanced APMs

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022 and later</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Payments through an Advanced APM</td>
<td>25%</td>
<td>25%</td>
<td>50%</td>
<td>50%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Percentage of Patients through an Advanced APM</td>
<td>20%</td>
<td>20%</td>
<td>35%</td>
<td>35%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>


### Table 3. Medicare-Only Partial QP Thresholds in Advanced APMs

<table>
<thead>
<tr>
<th>Payment Year</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024 and later</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Payments</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
<td>40%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Percentage of Patients</td>
<td>10%</td>
<td>10%</td>
<td>25%</td>
<td>25%</td>
<td>35%</td>
<td>35%</td>
</tr>
</tbody>
</table>

MIPS APM
APMs that do not meet threshold requirements to be categorized as Advanced APMs may be subject to MIPS and eligible to participate in the category known as “MIPS APM.” Participation in a MIPS APM allows for streamlined quality reporting based on APM-related performance. All eligible clinicians in a MIPS APM will receive identical MIPS scores. Each year, CMS will release a list of MIPS APMs prior to the performance period. The 2017 listing of MIPS APMs can be found at: https://qpp.cms.gov/learn/apms.

As written in the final rule, MIPS APMs are APMs that meet all of the following criteria:

- APM Entities participate in the APM under an agreement with CMS or by law or regulation.
- The APM requires that APM Entities include at least one MIPS eligible clinician on a Participation List.
- The APM bases payment incentives on performance (either at the APM Entity or eligible clinician level) on cost/utilization and quality measures.

For more information, the following organizations have developed resource guides on developing and transitioning to APMs:

- Center for Healthcare Quality and Payment Reform’s guide on “Improving Resource Use under MACRA” (http://www.chqpr.org/downloads/ImprovingResourceUseMeasurementUnderMACRA.pdf)
- Center for Healthcare Quality and Payment Reform’s guide on “Implementing Alternative Payment Models under MACRA” (http://www.chqpr.org/downloads/ImplementingAPMsUnderMACRA.pdf)

Resources
CMS has designed a new Quality Payment Program website, (https://qpp.cms.gov/), to explain the new program and help eligible clinicians identify measures and activities most meaningful to their practice or specialty. CMS also encourages eligible clinicians to contact their help desk with any questions regarding eligibility and/or implementation of the program:

CMS Quality Payment Program Service Center
(866) 288-8292
TTY: (877) 715-6222
QPP@cms.hhs.gov
Available Monday – Friday, 8:00am – 8:00pm Eastern Time

Act Now to Avoid Negative Payment Adjustments
NASS encourages its members to educate themselves on QPP program requirements as soon as possible to avoid future downward payment adjustments. Although the first year offers flexibilidad, under MIPS it is unknown whether this will extend to future years when payment risk becomes greater. NASS Advocacy, Health Policy and Research Councils continue to work tirelessly on behalf of NASS’ Membership to advocate for fair payment and less burdensome reporting requirements. As the program continues to evolve, NASS will keep membership apprised of QPP regulation through SpineLine, its website and newsletter communications.

References

Author Disclosures
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