Centers for Medicare & Medicaid Services Transition From Payments for Volume to Value:
Implications for North Carolina Physicians, Providers, and Patients

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The US Department of Health and Human Services and the Centers for Medicare & Medicaid Services have announced goals and timelines to transition from payments based on volume to payments based on value, quality, and efficient delivery of care. These value-based payments and alternative payment models will impact all health care professionals and provider organizations by encouraging better care, healthier people, and spending health care dollars wisely and efficiently.

The Centers for Medicare & Medicaid Services (CMS) have over the past several years been actively transitioning its payments for health care services from a system based primarily on volume of services to one that is increasingly based on the value (quality and cost) of services. This transition will result in a more person- and family-centered health care system, which will improve the health of each individual, reduce the cost of health care and care duplication, and increase the quality and coordination of care for beneficiaries across all settings of care. This commentary will lay out future directions and explore the implications for North Carolina health care providers, physicians, and health care consumers.

CMS' Medicare payment initiatives such as Hospital Value Based Purchasing, the Physician Quality Reporting System (PQRS), the Medicare Electronic Health Records (EHR) Incentive Program (Meaningful Use), the Medicare Shared Savings Program, and Accountable Care Organizations (ACOs) are probably familiar to the reader. Less familiar may be recent CMS initiatives such as the current physician value-based payment modifier program, which increases or reduces a physician's fee schedule payments by a factor that reflects quality and efficiency scores for a set of quality and cost measures [1], and the provisions of the recently enacted Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (referred to as MACRA), which establishes a new Merit-Based Incentive Payment System (MIPS) and incentives for participation in certain Alternative Payment Models (APMs) for physicians and other eligible clinicians [2].

In January 2015, the Secretary of the US Department of Health and Human Services (HHS) announced specific goals to further link Medicare fee-for-service payments to quality and value. The HHS goal is to have 85% of all Medicare fee-for-service payments tied to quality and value by 2016, and 90% by 2018 [3]. Equally and perhaps more importantly is the HHS target to link 30% of Medicare payments to quality or value through Alternative Payment Models (APMs) by the end of 2016, and 50% of payment through APMs by the end of 2018 [3]. This is the first time in the history of the Medicare program that explicit goals for value-based payments and alternative payment models have been established [3]. On March 3, 2016, HHS announced that an estimated 30% of Medicare payments had been successfully tied to alternative payment models that reward the quality of care over the quantity of services provided to beneficiaries. This achievement is nearly a year ahead of schedule [4].

Alternative Payment Models [5] include but are not limited to the Medicare Shared Savings Program, ACOs, Patient-Centered Medical Homes, and Bundled Payments [6]. For more detailed information on Medicaid delivery systems, managed care, and other integrated care models, the reader is referred to the following CMS website: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/delivery-systems.html.

In April 2015, the US Congress passed and the President signed MACRA into law. MACRA repealed the flawed Sustainable Growth Rate (SGR) formula for determining Medicare payments for clinicians' services and replaced it with a new framework to reward clinicians for providing clinical value over volume [7]. MACRA also streamlines and consolidates certain aspects of other CMS programs, such as the Physician Quality Reporting System (PQRS), the

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Physician Value Based Payment Modifier, and the Medicare EHR Incentive Program (Meaningful Use) into a single MIPS [7]. MIPS will combine these separate programs into a single program based on weighted performance scores in 4 categories: quality, resource use, clinical practice improvement activities, and advancing care information [7].

The separate payment adjustments under PQRS, the Physician Value Modifier, and the Medicare EHR incentive program (for physicians) will all sunset on the last day of 2018. Beginning January 1, 2019, payments to physicians and other eligible professionals (including physician assistants, nurse practitioners, certified registered nurse anesthetists, and clinical nurse specialists) will be based on performance on the new MIPS performance categories (See Table 1). Physicians' and other professionals' Part B Medicare physician fee schedule payments will be adjusted up or down generally by up to 4% beginning in 2019 and progressing upwards and downwards by a maximum of 9% in 2022 [2]. MIPS will be budget neutral so that the estimated total upward and downward adjustments will be equal. It is anticipated that the majority of all eligible clinicians will have their payments adjusted through the MIPS formula. Eligible clinicians in their first year of Medicare Part B participation, those who do not exceed a certain volume threshold (such as those serving a low number of Medicare patients), and certain participants who are significantly participating in an Advanced APM will not be subject to MIPS payment adjustments. MIPS applies to clinicians paid under the Medicare part B physician fee schedule. MIPS does not apply to hospitals or facilities.

MACRA does not change how any particular APM rewards value. Instead it creates extra incentives for clinicians to participate in Advanced APMs. APMs as defined by MACRA include CMS Innovation Center models (under Section 1115A), the Medicare Shared Savings Program, demonstrations under the Health Care Quality Demonstration Program, and other demonstrations required by federal law. Advanced APMs are APMs that meet certain criteria requiring the use of certified EHR technology, basing payment on quality measures comparable to those in MIPS, and either requiring participating entities to bear more than nominal financial risk for monetary losses or being a medical home model expanded under CMS Innovation Center authority.

Most physicians and practitioners who participate in APMs will be subject to MIPS and will receive favorable scoring under the MIPS clinical practice improvement activities performance category. Those who participate in Advanced APMs may be determined to be Qualifying APM participants

TABLE 1.

PROPOSED RULE

MIPS: Performance Category Scoring

Summary of MIPS Performance Categories

Performance Category	Maximum Possible Points per Performance Category	Percentage of Overall MIPS Score (Performance Year 1 - 2017)
Quality: Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-value measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.	80 to 90 points depending on group size	50 percent
Advancing Care Information: Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.	100 points	25 percent
Clinical Practice Improvement Activities: Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in certain medical homes earn full credit in this category, and those participating in Advanced APMs will earn at least half credit.	60 points	15 percent
Cost: CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.	Average score of all cost measures that can be attributed	10 percent

("QPs"). Clinicians and other professionals who participate in Advanced APMs and meet certain minimum thresholds of patients or payments through an Advanced APM for a year (25% or more in 2019 and 2020) will be excluded from MIPS and will receive a 5% lump sum bonus for that year (for years 2019–2024). Starting in 2026, QPs will receive a higher fee schedule update than those who participate in MIPS. Beginning in 2021, participation in some private payer or Medicaid APMs can count toward the thresholds to be a QP [2].

In summary, APMs—and Advanced APMs in particular—may offer greater potential risks and rewards than MIPS. In addition to those potential rewards, MACRA provides a bonus payment to physicians and practitioners committed to operating under Advanced APMs [2]. These new programs will afford physicians and other professionals more incentives and opportunities to be rewarded for providing higher quality care at lower costs. It is anticipated that, through these consolidated programs, the administrative burden of practice will be reduced. This movement towards value-based payments and alternative payment models both in the Medicare, Medicaid, and private payer sectors will help to create a health care system that provides better care, makes people healthier, and spends health care dollars more wisely and efficiently [7].

The reader is advised to periodically consult the following CMS website to keep abreast of the most recent regulatory, policy, and operational updates as MACRA, MIPS, and APMs are implemented: http://go.cms.gov/QualityPaymentProgram. NCMJ

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