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Out with the old, In with the new: The Medicare Access and CHIP Reauthorization Act of 2015

After 18 years of "doc fixes," President Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) on April 17, paving the way for changes in how Medicare providers, including registered dietitian nutritionists (RDNs) are paid in the future. This landmark legislation permanently repeals the Sustainable Growth Rate (SGR); provides a period of small, predictable increases in Medicare payment rates under the Physician Fee Schedule (PFS); and further propels the Medicare provider payment system along its current trajectory to integrate its various incentive programs and link payment to quality and value. MACRA incorporates multiple provisions that impact various players in the health care system, including hospitals, skilled nursing facilities, home health agencies, and more. What does the future have in store for RDNs? While many details of MACRA await rule-making by the Centers for Medicare & Medicaid Services (CMS), here is what we know right now.

The new payment path

Step one: Period of predictable rate increases

Current payment rates under the Medicare PFS remain in effect through June 30, 2015. Starting July 1, 2015, payment rates will increase by 0.5% and will continue to do so annually (on January 1 of each year) through 2019.

Step two: Period of stability

From 2020 through 2025, payment rates will remain unchanged (i.e., 0% increase).

See **New**, page 4

Inside:

Choose your incentive payment path

Participation in the Centers for Medicare & Medicaid Services (CMS) alternative payment models (APMs) could be a rewarding experience for registered dietitian nutritionists (RDNs), as these new models will offer financial incentives to participating providers. RDNs will first need to learn some new acronyms related to the new value-based payment system.

Alternate payment models

Beginning in 2019 and ending in 2024, providers participating in one of CMS's APMs, such as Pioneer Accountable Care Organizations (ACOs), Shared Savings ACOs and demonstration projects such as the Comprehensive Primary Care initiative, will be eligible for an additional 5% incentive payment. To be considered a participant in an APM, at least 25% of the provider's payments must come from the APM in 2019 and 2020, with the required percentage rising to 50% in 2021 and 2022 and 75% thereafter.

To support reporting and payment under APMs, CMS will be developing care episode and patient condition groups and classification codes. In addition, CMS will develop patient relationship categories and codes to define and distinguish the relationship and responsibility of a practitioner to a patient at the time of furnishing a service. For example, the practitioner may have primary responsibility for a patient's general and ongoing care, may be the lead provider during an acute episode, may provide services in a supportive role or may provide services only as ordered by another practitioner.

Merit-based Incentive Payment System

Alternatively, Medicare providers can participate in the Merit-based Incentive Payment System (MIPS). Slated to roll out for physician providers in 2019, MIPS ends separate payments for the following CMS incentive programs and folds them under a single new system:

- EHR Meaningful Use Incentive Program
- Value-based payments
- Physician Quality Reporting System (PQRS)

MIPS annually measures Medicare Part B providers in four performance categories to derive a "MIPS score" (0 to 100), which can significantly change a provider's Medicare reimbursement in each payment year. Under this new program, providers could be eligible for bonus payments or subject to downward payment adjustments; the payment adjustments will depend on the provider's rank compared with their peers and be based on a composite performance score using the following categories:

- **Quality**: MIPS-eligible professionals may choose to report from a list of quality measures. Development of new measures will focus on outcome measures, patient experience

See **Path**, page 2

MACRA beyond Medicare Part B

The reach of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) contains substantial changes to the payment and delivery of health care services and extends into programs across a wide range of practice settings, which has the potential to affect registered dietitian nutritionists (RDNs) and nutrition and dietetics technicians, registered (NDTRs) in numerous ways. Here is a general outline of the temporary and permanent effects MACRA has on a variety of health care programs and services.

Through fiscal year (FY) 2017, MACRA extends:

- Increased inpatient hospital payment adjustments for certain low-volume hospitals
- The Special Diabetes Program for Type 1 Diabetes and for Indians
- The Maternal, Infant and Early Childhood Home Visiting Program
- Funding for Community Health Centers, the National Health Service Corps and Teaching Health Centers
- The Children's Health Insurance Program (CHIP)
- Express Lane Eligibility
- The Childhood Obesity Demonstration Project

Beyond 2017, MACRA also extends:

- Medicare Advantage plans for special needs individuals through FY2018
- Contract terms for Medicare Administrative Contractors (MACs) from 5 to 10 years
- Transitional Medical Assistance (TMA) permanently

MACRA also prohibits the inclusion of Social Security account numbers on Medicare cards. By 2019 Social Security numbers may not be displayed or coded on or embedded in Medicare cards. A summary of MACRA can be found at: www.congress.gov/bill/114th-congress/house-bill/2.

Path, from page 1

measures, care coordination measures and measures of appropriate use of services. Reporting may include data submitted to non-Medicare payers.

- **Resource use**: Performance in this area will be based on claims data for Medicare Parts A and B and potentially Part D.
- **Clinical practice improvement activities**: This measure of performance is new and includes:
  - Expanded practice access (e.g., same-day appointments, after-hours access to clinician advice)
  - Population management (e.g., monitoring health conditions of individuals to provide timely health care interventions)
  - Care coordination (e.g., timely exchange of clinical information to other providers)
  - Beneficiary engagement (e.g., self-management training, shared decision-making)
  - Patient safety and practice assessment (e.g., use of clinical checklists)
  - Participation in an APM, with consideration given to small practices and practices located in rural areas and in health professional–shortage areas
- Meaningful use of certified EHR technology

The MIPS Composite Score table shows the weighting of these categories for the purposes of establishing the composite score. Payments will be adjusted (up or down) by up to 4% in 2019, and adjustments will gradually increase to 9% for 2022 and beyond. The Secretary of Health and Human Services (HHS) will establish the performance threshold for a 3-year period based on mean or median performance scores for all MIPS-eligible professionals. All providers who achieve a composite score above this performance threshold will be eligible for positive incentive payments. The higher a provider's composite score, the higher the "rate adjustment factor." For example, in 2019 a provider who receives a performance score of 100 gets a 4% adjustment, a provider who receives a performance score of 50 gets no adjustment, and a provider who receives a score of 0 gets a –4% adjustment. In addition, through 2024, bonus payments (up to a total of $500 million annually) will be made to providers with a composite score in the top 25th percentile. Distribution of percentages for the categories within the composite score for Medicare providers, such as RDNs, who are not eligible for all of these programs will be adjusted, although the exact numbers remain to be seen.

MIPS Composite Score

Data will continue to be shared with the public through the Physician Compare website, with providers continuing to have the opportunity to review their data and submit corrections before the information is posted.

MIPS Composite Score

Category	Weight
Quality	30%
Resource Use	30%
Clinical practice improvement activities	15%
Meaningful use	25%

When will these changes affect RDNs?

In CMS's usual style, these new paths to payment will roll out first to physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists in 2019 and then be applied in their third year (2021) to Medicare nonphysician providers such as RDNs. CMS will define the performance years and other details of the MIPS program in a final rule anticipated to be published in the Federal Register by the end of 2016. Future issues of *MNT Provider* will share additional details as they are made available.

For an overview of current PQRS reporting options and requirements, visit: www.eatrightpro.org/resource/practice/getting-paid/nuts-and-bolts-of-getting-paid/getting-started-with-pqrs. The Physician Compare website can be found at: www.medicare.gov/physiciancompare/search.html.

QUESTION CORNER

Q: Who's paying for the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)?

A: The cost of implementing MACRA is being borne by multiple Medicare providers as well as Medicare beneficiaries themselves. By the year 2018, some providers will see payment rates capped, and a subset of beneficiaries will begin sharing more of the burden for coverage as follows.

Medicare providers

Starting in fiscal year (FY) 2018, the following providers will see a reduction in their Medicare payments:

- Skilled nursing facilities: Annual payment updates will be capped at 1%.
- Home health agencies: Annual payment updates will be capped at 1%.
- Hospice: Annual payment updates will be capped at 1%.
- Long-term care hospitals: Annual payment updates will be capped at 1%.
- Inpatient hospital payments: Annual payment updates of 0.5% from FY2018 to FY2023 will replace a scheduled payment increase of 3.2% in FY2018.

(Note: The federal fiscal year runs from October 1 through September 30.)

Medicare beneficiaries

Starting in 2020, Medicare supplemental policies that provide coverage of the Part B deductible may not be sold or issued to newly eligible Medicare beneficiaries. Beginning 2018, higher income beneficiaries will pay a higher percentage of their Part B premiums, up to 80% for individuals with a modified adjusted gross income more than $160,000.

Q: What assistance will the Centers for Medicare & Medicaid Services (CMS) offer to individual providers or small group practices for participating in the Merit-based Incentive Payment System (MIPS)?

A: Recognizing the challenges that certain subsets of eligible professionals could face in participating in MIPS, CMS plans to offer several forms of assistance to providers. Individual providers or small group practices with no more than 10 MIPS-eligible professionals may choose to become part of a virtual group for the purposes of MIPS. Congress has also set aside $20 million annually from 2016 to 2020 to make technical assistance available to help small practices improve MIPS performance or transition to alternative payment models. Technical assistance will be available to practices of 15 or fewer professionals, with priority given to such practices located in rural areas, health professional–shortage areas, medically underserved areas and practices with low MIPS composite scores. Many of the remaining details still need to be worked out by CMS. Watch future issues of the *MNT Provider* for additional information as it becomes available. To read current and past issues of the *MNT Provider*, visit: www.eatrightpro.org/resources/news-center/in-practice/mnt-provider.

Comparison of MACRA to current policies

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a complex law with many moving parts. The following table summarizes payment for physicians under the old system versus the new one and can help you make sense of how MACRA compares to former policies. Policies relevant to registered dietitian nutritionists (RDNs) will unfold through future rule-making by the Centers for Medicare & Medicaid Services and are anticipated to roll out later than the timeline for physicians.

	Current Law				H.R. 2 PL 114-10		
Year	**Max P4P Penalties***	**Max P4P Bonuses**	**Updates**	**Sequester**	**Max P4P Penalties**	**Max P4P Bonuses**	**Updates**
2014	-2%	1.5%	0.5%	-2%	No change	No change	0.5%
2015	-4.5%	VBM**	-21%	-2%	No change	No change	0.5% on 7-15
2016	-6%	VBM		-2%	No change	No change	0.5%
2017	-9% or more	VBM		-2%	No change	No change	0.5%
2018	-10% or more	VBM		-2%	No change	No change	0.5%
2019***	-11% or more	VBM		-2%	-4%	4%*	0.5%
2020	11% or more	VBM		-2%	-5%	5%*	0%
2021 onward	-11% or more	VBM		-2% (thru 2023)	-7%	7%*	0%

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*P4P = Pay for performance. Includes EHR Meaningful Use Incentives (RDNs are not considered eligible professionals for this program).

**VBM = Value-Based Modifier (RDNs are not eligible until 2019).

***RDNs are not eligible for the Merit-based Incentive Payment System (MIPS) until 2021.

New, from page 1

Step three: Pay for value

In 2026 and beyond, Medicare providers will be given incentives to participate in alternate payment models (APMs), such as Patient-Centered Medical Homes and Accountable Care Organizations—those who participate will see a 0.75% annual increase in their fee-for-service payments under the PFS, while those who do not participate in APMs will see only a 0.25% annual increase. Bonus payments of up to 5% will be available for practices participating in APMs.

Some things remain the same (for now)

The sequester, a 2% across-the-board cut in Medicare provider payments established under the Budget Control Act of 2011, continues in effect through 2023 unless Congress enacts legislation to amend that act.

Business will also continue as usual for eligible providers (EPs), including RDNs, under the Physician Quality Reporting System (PQRS). EPs who do not meet satisfactory reporting requirements under PQRS will continue to be subject to a downward payment adjustment of 2%. The program will sunset at the end of 2018, when it becomes folded into the new two-track payment system described below.

Moving forward: Paying for value

Building on top of the fee-for-service system, Medicare providers will be able to select from one of two paths to incentive payments: the Merit-based Incentive Payment System (MIPS) or APMs. Since sizeable financial advantages will be offered to value-based providers, RDNs should be thinking about how to participate in some of these non-fee-for-service payment models. The Academy of Nutrition and Dietetics Nutrition Services Payment Committee has established an Accountable Payment Models Task Force to work on developing such models for nutrition services. For more information about MIPS and APMs, see the accompanying article, "Choose your incentive payment path," on page 1.

But wait, there's more!

In 2015, CMS began paying primary care providers for the chronic care management (CCM) services they provided to their Medicare patients. MACRA builds on that new benefit by removing the requirement that an annual wellness visit or initial preventive physical examination be furnished as a condition of payment for CCM services. Plus, MACRA includes an education and outreach campaign for providers and beneficiaries, with a focus on underserved rural populations and racial and ethnic minority populations, to promote utilization of such services. RDNs potentially can help provide such services as primary care practice employees or contractors.

Additionally, if you have chosen to opt-out of Medicare Part B, you no longer need to apply to do so every 2 years. Instead, your opt-out election will automatically continue for each 2-year period unless you give a minimum of 30 days notice of your desire to end it.

Are you or your hospital using certified electronic health record (EHR) technology? In an effort to support widespread interoperability of such systems, MACRA states that users cannot have "knowingly and willfully taken action" (such as disabling functionality) to block sharing of information.

Will MACRA work?

No one can predict with certainty whether the new payment system established by MACRA will achieve its goals to improve delivery and payment of health care under the Medicare program. As a result, MACRA requires numerous evaluation studies and reports must be given to Congress no later than Oct. 1, 2021, to help assess the effectiveness of various components of this new payment system. MACRA also requires a study on the use of telehealth services and remote patient monitoring under federal programs.

Summary

MACRA marks the beginning of a new era in payments for Medicare providers, moving away from a volume-based systems toward one that rewards value. Many of the details are yet to be defined, but the bottom line is MACRA is laying the groundwork for a significant transformation in how RDNs and other health care professionals are paid. Even as we may celebrate the demise of the SGR, we now must prepare for new payment and delivery models. The good news is that the future may be bright for savvy RDNs who are able to find their niche within accountable payment models. Look to future issues of the *MNT Provider* for ongoing updates on this important topic as well as Academy resources designed to help members integrate their services into these evolving models of health care delivery and payment. For more information about integrating RDNs into emerging health care delivery models, visit: www.eatrightpro.org/resource/practice/getting-paid-in-the-future/expanding-payment-and-coverage/integrating-rdns-into-emerging-health-care-delivery-and-payment-models. To learn about emerging health care delivery and payment models, visit: www.eatrightpro.org/resources/practice/getting-paid-in-the-future/emerging-health-care-delivery-and-payment.

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Telephone: 312/899-0040

Editor: Mara Bujnowski, MAEd, RD
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