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MACRA Proposed Rule:
CMS Unveils Plan for New Medicare Physician Payment System

May 2016

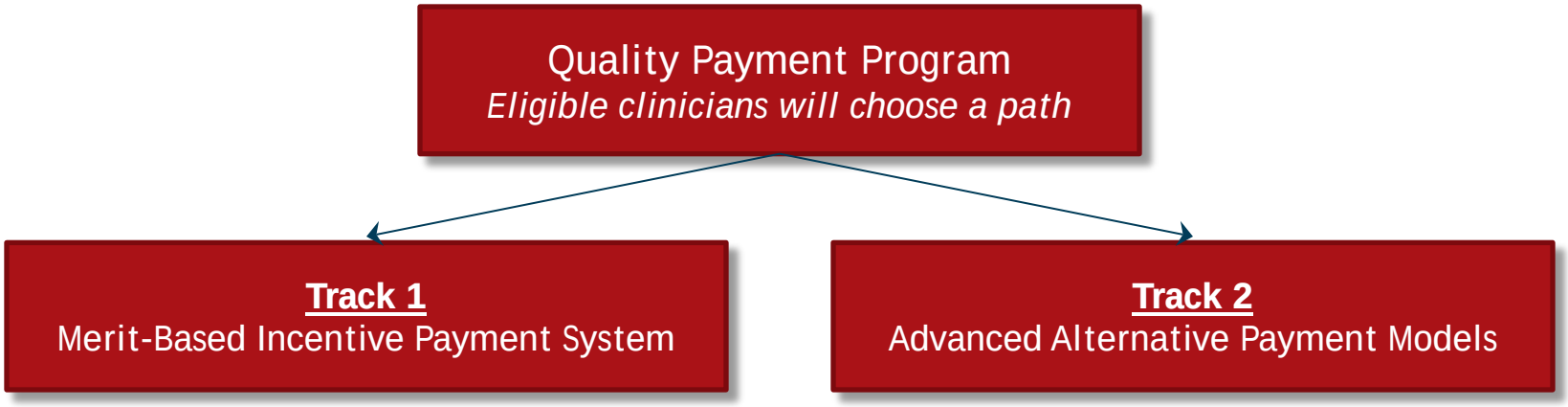
Important Dates

- ✓ Legislation Enacted: April 16, 2015
- ✓ Posted: April 27, 2016
- ✓ Published: May 9, 2016
- ✓ Comment Deadline: June 27, 2016 (www.regulations.gov)
- ✓ Expected Release of Final Rule: Fall 2016

Overview

Beginning in 2017, most physicians will be required to choose whether to be evaluated based on performance measures and activities under the Merit-based Incentive Payment System (MIPS) or to participate in an Advanced Alternative Payment Model (APM).

- Physicians choosing the MIPS pathway will have payments increased or decreased based on relative performance.
- Physicians choosing the APM pathway will receive incentive payments for their participation.



MIPS vs. Advanced APMs

Details	MIPS	Advanced APMs
FFS Adjustments (Adjustment to annual update)	**Yes** (+/- 4% beginning in 2019; goes up to +/- 9% by 2022) (A scaling factor, not to exceed 3.0, can be applied to the positive adjustment factor to maintain budget neutrality)	**Not Applicable**
Bonuses and Other Payments	**Bonus to Top 25%** Providers in top 25% of all aggregate scores receive additional positive adjustment factor (2019 – 2025); bonus capped at 10% per eligible provider	**5% Incentive Payment** (2019-2024)
Annual Update (Beginning in 2026)	**0.25%**	**0.75%**
Criteria for Participation	**MIPS Reporting Requirements in Four Performance Categories**	**Participation Thresholds** Threshold based on payments received through an APM or patient percentage (varies by year)

Merit-based Incentive Payment System

MIPS Eligible Participants

- **Physicians and Practitioners Eligible to Participate in MIPS**
  - Physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and groups that include such clinicians
  - From 2021 the Secretary can add other providers to MIPS

- **Physicians and Practitioners Not Subject to MIPS**
  - Newly Medicare-enrolled eligible clinicians
  - Qualifying APM Participants (QPs)
  - Certain Partial Qualifying APM Participants (Partial QPs)
  - Clinicians who fall under the proposed low-volume threshold
    - Those with less than $10,000 in allowable claims and fewer than 100 Medicare patients would be considered low volume

MIPS Performance Period and Data Submission

2019 MIPS Program

Reporting and Measurement Period	January 1, 2017 – December 31, 2017
Data Submission Deadlines	
Qualified Registry, QCDR, EHR Submission, Attestation	January 2, 2018 – March 31, 2018
Claims	No later than 90 days following the close of the performance period
CMS Web Interface	8-week period following the close of the performance period

MIPS Performance Categories

Category	Reporting Criteria	2019 Weight
Quality (Replaces the Physician Quality Reporting System and the quality component of the Value Modifier Program)	• Six measures with at least one cross-cutting measure • Outcome measure if available • If no outcome measure, one other high priority measure • Quality measures can be reported either individually or from a specialty-specific measure set	**50%**
Advancing Care Information (Replaces the Meaningful Use program)	• Significant changes from current Meaningful Use program (*e.g.*, no longer requires reporting on the Clinical Decision Support and the Computerized Provider Order Entry measures) • Report on six objectives and measures proposed by CMS (Base Score) • Report on select measures that emphasize patient care and information access (Performance Score)	**25%**
Clinical Practice Improvement Activities	• Measures a provider's participation in clinical improvement-related activities (*e.g.*, expanded practice access, such as same-day appointments for urgent needs) • CMS generally encourages but does not require a minimum number of CPIAs	**15%**
Resource Use (Replaces the cost component of the Value Modifier Program)	• Continues two measures from the Value Modifier program: total costs per capita for all attributed beneficiaries, and Medicare Spending per Beneficiaries with minor technical adjustments • Episode-based measures, as applicable to the MIPS eligible clinician	**10%**

MIPS Performance Category Scoring

Category	Scoring Criteria
Quality	**Maximum 90 points** • 10 points for each of the six measures reported and 10 points for each of the three population measures derived through claims data (scoring will vary for CMS Web Interface option) • 2 bonus points for each outcome and patient experience measure reported • 1 bonus point for other high priority measure reported in addition to the one high priority measure required • Bonus also provided for use of CEHRT for activities described in the Proposed Rule • CMS also seeks comments on three alternative options to incorporate improvement into the scoring methodology moving forward
Advancing Care Information	**Maximum 100 points** • Possible to score more than 100 points, but 100 points would be the maximum applied • Base score accounts for 50 points; clinicians must provide the numerator/denominator or yes/no for each of six proposed objectives and measures • Performance score accounts for up to 80 points for reporting on other select measures • Bonus point for public health registry reporting (in addition to the required immunization registry)
Clinical Practice Improvement Activities	**Maximum 60 points** • Activities divided into two categories: medium-weighted activities (10 points) and high-weighted activities (20 points) • Proposed Rule Table H lists all activities; Table 23 lists all high-weighted activities
Resource Use	**No Maximum** • Each cost measure will be worth 10 points, but total maximum score will vary based on number of measures that apply; score based on percentage of points from total possible (See Table 22 in Proposed Rule) • CMS will develop measure-specific benchmarks; clinicians will be assessed based on how they perform to benchmark • CMS proposes to average all the scores of all the resource use measures attributed to the MIPS eligible clinician • If a clinician does not have enough patient volume for any cost measures, then a score would not be calculated

MIPS Eligible Clinicians Participating in APMs

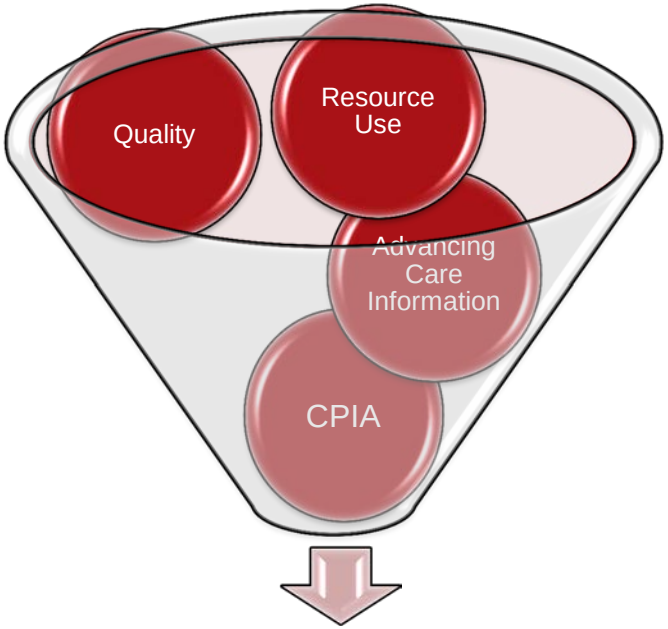
- To determine whether clinicians meet the requirements for the Advanced APM track, all clinicians must report through MIPS in the first year.
- CMS proposes to establish a scoring standard for MIPS eligible clinicians participating in certain types of APMs
  - This standard would not apply to MIPS eligible clinicians involved in:
    - APMs that include only facilities as participants (such as the Comprehensive Care for Joint Replacement Model (CCJR))
    - APMs that do not base payment on cost/utilization and quality measures (Accountable Health Communities Model)

Non-Patient-Facing Eligible Clinicians

Certain practitioners (in specialties such as anesthesiology, diagnostic radiology, and nuclear medicine and pathology) could be deemed "non-patient facing" and be granted special exceptions from various reporting, measurement and adjustment obligations.

- Defined as MIPS eligible individual or group that bills **25 or fewer patient-facing encounters** during a performance period
- Exemption from reporting a cross-cutting measure
- Different requirements for the CPIA category

MIPS Payment Adjustment



Composite Score
(Between 0 – 100)

Composite Score

Payment ⇧ if composite score is above threshold

Annual Threshold
Median or mean of composite score from previous performance period

Payment ⇩ if composite score is below threshold

Year	Positive Adjustment*	Negative Adjustment
CY 2019	4%	-4%
CY 2020	5%	-5%
CY 2021	7%	-7%
CY 2022 and Beyond	9%	-9%

* CMS can **increase positive adjustments by 3X** to maintain budget neutrality

MIPS Payment Adjustment Proposals

- **Establishing 2019 Threshold**
  - Because 2017 is the first MIPS Performance Year, CMS proposes to model the threshold based on the following 2014 and 2015 data sources: Part B allowed charges, PQRS data submissions, Quality Resource Use Reports (QRURs) and Supplemental Quality Resource Use Report (sQRURs) feedback data, and Medicare and Medicaid EHR Incentive Program data

- **Performance Threshold Level**
  - A level where approximately half of the eligible clinicians would be below the performance threshold and half would be above the performance threshold

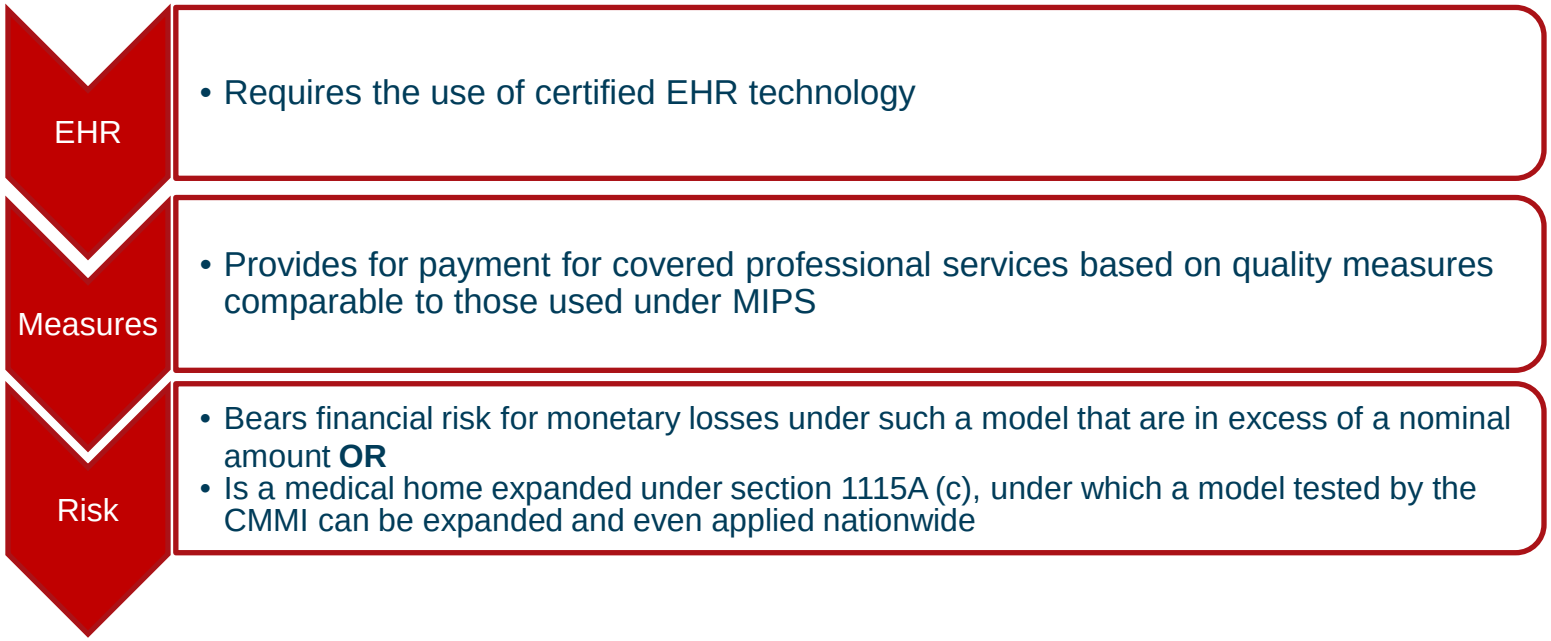
- **Additional Performance Threshold for Exceptional Performance**
  - 25th percentile of the range of possible Composite Performance Score (CPS) above the performance threshold
    - Example from the Proposed Rule: if the performance threshold is 60, then the range of possible CPSs above the performance threshold would be 61–100. The 25th percentile of those possible values would be 70.

- **Scaling Factor for Budget Neutrality**
  - CMS will calculate and apply a scaling factor to ensure budget neutrality

Advanced APMs

Eligible APMs

- To be exempt from MIPS and qualify for the Advanced APM bonuses and updates, eligible clinicians must participate in an eligible APM entity.
- An APM will qualify as an eligible APM entity if it meets the following requirements



Advanced APM Requirements

Statutory Requirements	CMS Proposal
Participants required to bear financial risk	APM must withhold payment, reduce rates or require the entity to make payments if its actual expenditures exceed expected expenditures. ▪ **Total risk** (maximum amount of losses possible under the Advanced APM) must be **at least 4 percent** of the APM spending target. ▪ **Marginal risk** (the percent of spending above the APM benchmark (or target price for bundles) for which the Advanced APM Entity is responsible (i.e., sharing rate) must be **at least 30 percent**. ▪ **Minimum loss rate** (the amount by which spending can exceed the APM benchmark, or bundle target price, before the Advanced APM Entity has responsibility for losses) must be **no greater than 4 percent**. Special Rules for Medical Homes: Under the statute, medical home models that have been expanded under the Innovation Center authority qualify as Advanced APMs regardless of whether they meet the financial risk criteria. While medical home models have not yet been expanded, the proposed rule lays out criteria for medical home models to ensure that primary care physicians have opportunities to participate in Advanced APMs.

Advanced APM Requirements (cont.)

Statutory Requirements	CMS Proposal
Payments based on quality measures comparable to those used in the MIPS quality performance category	▪ Payment on quality measures that are evidence-based, reliable and valid. ▪ At least one such measure must be an outcome measure if an outcome measure appropriate to the Advanced APM is available from the MIPS measure list.
Participants required to use certified EHR technology	▪ Advanced APM must require that **at least 50 percent** of the clinicians use certified EHR technology to document and communicate clinical care information in the first performance year. ▪ Requirement **increases to 75 percent** in the second performance year.

Eligible APMs

CMS will update the Advanced APM list annually and will continue to modify other models in coming years to help them qualify as Advanced APMs.

ELIGIBLE APMS

- **Comprehensive ESRD Care Model** (LDO Arrangement)
- **Comprehensive Primary Care Plus (CPC+)**
- **Medicare Shared Savings Program Track 2**
- **Medicare Shared Savings Program Track 3**
- **Next Generation ACO Model**
- **Oncology Care Model – Two Sides Risk (2018)**

CMS requests comments on how it might change the design of the Comprehensive Care for Joint Replacement (CJR) model in future rulemaking to make it an Advanced APM.

Timeline and Participation Categories

Timeline

2019

- All providers participate in MIPS in the first year
- APM Option 1: Medicare Only

2020

- APM Option 1: Medicare Only

2021 & Beyond

- APM Option 1: Medicare Only
- APM Option 2: All Payer Combination (Medicare, Private Payer and Medicaid)

Participation Categories

The Advanced APM Entity would provide a list of eligible clinicians associated with its APM to CMS. CMS proposes to make the QP determination at the group level (with some exceptions), which would apply to all individual eligible clinicians in the group.

Qualifying APM Participant	Partial Qualifying APM Participant	Intermediate Option
▪ Meets **higher threshold** based on payments received through an APM or patient percentage (varies by year) ▪ **Eligible** for APM bonuses and annual updates ▪ **Not subject** to MIPS	▪ Meets **lower threshold** based on payments received through an APM or patient percentage (varies by year) ▪ **Not eligible** for APM bonuses and annual updates ▪ **Not subject** to MIPS	▪ Participates in APMs but does not meet QP or Partial QP thresholds ▪ NOT eligible for APM bonuses and annual updates ▪ Subject to MIPS ▪ CMS proposes to establish a scoring standard for MIPS eligible clinicians participating in certain types of APMs to reduce the reporting burden

Participant Thresholds: Option 1

Requirements for Incentive Payments for Significant Participation in Advanced APMs

Clinicians must meet payment or patient requirements. See Figures E, F, G, J and K in the Proposed Rule for decision trees illustrating CMS's process to determine QP and Partial QP status.

OPTION 1: MEDICARE ONLY

Status	Threshold	2019 – 2020	2021 – 2022	2023 & Beyond
QP	Payment	25%	50%	75%
	Patient	20%	35%	50%
Partial QP	Payment	20%	40%	50%
	Patient	10%	25%	35%

***Participation in multiple APMs**:* CMS proposes that if an individual eligible clinician who participates in multiple Advanced APMs does not achieve QP status through participation in any single APM, CMS would assess the eligible clinician to determine QP status based on combined participation in Advanced APMs.

Source: Table 2 from the CMS, *MACRA Quality Payment Program Fact Sheet,* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf

Participant Thresholds: Option 2

Requirements for Incentive Payments for Significant Participation in Advanced APMs

Clinicians must meet payment ***or*** patient requirements for the Medicare ***and*** All Payer Threshold.

OPTION 2: ALL PAYER COMBINATION

Status	Threshold	2019 – 2020	2021 – 2022	2023 & Beyond
QP	***Medicare Threshold***			
	Payment Threshold	N/A	25%	25%
	Patient Threshold	N/A	20%	20%
	All Payer Threshold			
	Payment Threshold	N/A	50%	75%
	Patient Threshold	N/A	35%	50%
Partial QP	***Medicare Threshold***			
	Payment Threshold	N/A	20%	20%
	Patient Threshold	N/A	10%	10%
	All Payer Threshold			
	Payment Threshold	N/A	40%	50%
	Patient Threshold	N/A	25%	35%

CMS will publish an annual list of approved All Payer Advanced APMs prior to the beginning of the performance period.

Data Must Be Submitted to CMS: *For the All Payer Combination option, the APM or the eligible clinicians are required to submit to CMS financial data, an attestation on the accuracy of the financial data, an outcome measure if available, or an attestation there is no applicable outcome measure on the MIPS list of quality measures.*

Advanced APMs 2019 Incentive Payment

- **2019 Incentive Amount**
  - 5 percent of the estimated aggregate amounts paid for Medicare Part B covered professional services furnished by the eligible clinician from the preceding year across all billing TINs associated with the QP's NPI
    - CMS proposes to exclude performance payment adjustments (e.g., PQRS) or other types of payment (e.g., shared savings) when calculating the estimated aggregate payment amount
    - In the event that an eligible clinician is no longer affiliated with the TIN associated with the QP's participation in the Advanced APM Entity that met the applicable QP threshold during the QP Performance Period, CMS makes the APM Incentive Payment to the TIN listed on the eligible clinician's CMS-588 EFT Application form
- **2019 Incentive Payment Timeline**
  - Claims submitted with dates of service from January 1, 2018, through December 31, 2018, and processing dates of January 1, 2018, through March 31, 2019
  - CMS estimates payments would be made in mid-2019

More Information

- McDermottPlus MACRA Resource Center
- CMS MACRA website
- CMS Factsheet: MIPS − Quality Payment Program
- CMS Factsheet: MIPS − Advancing Care Information