

FINAL MACRA RULE OUTLINES MIPS STRUCTURE, SETS HIGH BAR FOR ADVANCED ALTERNATIVE PAYMENT MODELS

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On October 14, 2016, the Centers for Medicare & Medicaid Services (“CMS”) released the highly anticipated final rule that would implement major provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”) affecting physician payment under the Medicare program (“Final Rule”). The Final Rule sets forth an approach to structuring and paying physicians under two “tracks” in the new Quality Payment Program—the Merit-Based Incentive Payment System (“MIPS”) and advanced alternative payment models (“Advanced APMs”).

The MACRA established two tracks for reimbursing physicians under the Medicare physician fee schedule starting in 2019—the MIPS and Advanced APMs. The MIPS combines the existing Physician Quality Reporting System (“PQRS”), Value Modifier (“VM”), and Meaningful Use programs, along with a new measure category for Clinical Practice Improvement Activities (“CPIAs”), into a single performance measurement and payment adjustment program. CMS expects **most** providers will report measures and be subject to payment adjustments under the MIPS, as it represents the default payment mechanism for physicians not participating in Advanced APMs.

The Advanced APM track exempts qualifying APM professionals (“QPs”) and partial qualifying APM professionals (“Partial QPs”) that satisfy thresholds for revenue or patient lives under Advanced APMs from MIPS reporting and payment adjustments. The MACRA contained significant incentives to encourage clinicians to participate in Advanced APMs, including a 5% bonus from 2019 through 2024 on a clinician’s total professional Medicare claims for the prior year. As we detail further below, the CMS set a high bar for payment models that satisfy the Advanced APM criteria. Indeed, 95% of the ACOs currently participating in the Medicare Shared Savings Program (“MSSP”) do not qualify as an Advanced APM under CMS’s criteria. This is a significant development and will have downstream implications for providers’ transition to more challenging APMs that involve downside risk.

MERIT-BASED INCENTIVE PAYMENT SYSTEM

As noted above, a majority of physicians are likely to remain in the MIPS. MIPS eligible clinicians would include all physicians, nurse practitioners, physician assistants, clinical nurse specialists, registered certified nurse anesthetists, and groups including such professionals who are not QPs, Partial QPs, or subject to one of the very narrow exclusions. Measurement across the performance categories would occur at both the individual (NPI) and group (TIN) level. CMS is using the full 2017 calendar year as the performance year on which 2019 payment adjustments will be based.

In general, the measures used in the MIPS resemble those used in the PQRS, VM, and Meaningful Use programs. However, CMS has implemented significant changes to how performance will be scored and has provided clinicians greater flexibility in choosing the measures under which they will be evaluated. Below is a brief explanation of how clinicians are measured under each performance category:

Quality. Eligible clinicians or groups report at least six quality measures, including a cross-cutting measure and at least one outcome measure or other high priority measure. Clinicians and groups are permitted to select the measures against which they will be evaluated from a list of all MIPS measures or a set of specialty-specific measures (which may include fewer than 6 measures). CMS allows different standards for non-patient-facing clinicians because of the relative dearth in specialty-specific measures for some specialties.

Resource Use. This measure is calculated for attributed Medicare beneficiaries using the (1) total per-capita cost for all attributed beneficiaries measure; (2) the Medicare spend per beneficiary measure; and (3) newly proposed condition and episode-based measures. CMS will adjust data to reflect differences in geographic payment rates, beneficiary risk factors, and physician specialties. CMS evaluates performance at the individual (TIN/NPI) and group (TIN) levels using attribution logic similar to that found in the VM program.

CPIA. This is a new measure category for the MIPS that encourages physicians to adopt clinical delivery models and capabilities that are consistent with CMS’s Triple Aim goals. To achieve the highest potential score, clinicians or groups choose 3 high-weighted CPIAs (20 points each), 6 medium-weighted CPIAs (10 points each), or any other CPIA combination to achieve a total of 60 points. Clinicians and groups participating in APMs would automatically receive 30 points (50% of CPIA total), and those in patient-centered medical homes automatically receive the full 60 points (100% of CPIA total). Other CPIA measure subcategories relate to expanded practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, achieving health equity, emergency response and preparedness, and integrated behavioral and mental health.

Advancing Care Information. This measure category replaces the Meaningful Use program and aligns the performance period with the other measure categories. Clinicians that report measures under the quality performance category using certified EHR technology are treated as having satisfied the CQM reporting requirement under current law. Performance is assessed and aggregated at the group level as if it would have been submitted individually. Half of the score is based on reporting numerator and denominator figures for measures in Stage 3 of the Meaningful Use program. The remaining 50% is based on clinicians’ performance on 8 measures. A bonus point is awarded for reporting to public health and clinical data registries. The scoring method on the performance portion provides multiple routes for clinicians to achieve greater than a 100% total score, which helps alleviate concerns that practices with less advanced capabilities will be penalized, and that scoring will be “all or nothing.”

The weighting for MIPS performance categories that is used to determine the composite performance score and the MIPS payment adjustment are as follows:

PERFORMANCE CATEGORY	2019	2020	2021 AND BEYOND
Quality	50%	45%	30%
Resource Use	10%	15%	30%
CPIA	15%	15%	15%
Advancing Care Information	25%	25%	25%

CMS also included a reporting and scoring mechanism for eligible clinicians participating in so-called MIPS APMs (not to be confused with Advanced APMs) that have separate reporting requirements for quality and cost/efficiency. For qualifying MIPS APMs, CMS permits APM entity groups (i.e., all clinicians on the APM participant list) to aggregate clinician performance data on APM measures to satisfy their reporting obligation

under the MIPS. CMS will evaluate the aggregated data and assign a MIPS composite score and corresponding payment adjustment to all clinicians in the APM entity group (i.e., all clinicians on the APM participant list). CMS will retain the authority to reweight MIPS scores to reflect the differences between the standard MIPS measure sets and the measures reported through each APM. This approach should minimize administrative burden and any conflicts that might otherwise result from the overlap between reporting measures under both the MIPS and various APMs.

ADVANCED ALTERNATIVE PAYMENT MODELS

The Final Rule sets forth the minimum criteria for an Advanced APM, which must be satisfied for eligible clinicians to be exempt from MIPS and eligible to receive the 5% incentive payment starting in 2019. To the disappointment of many in the provider community, CMS did not include many popular APMs in its definition of Advanced APMs. Under the proposed criteria, MSSP Track 1 ACOs, the Bundled Payments for Care Improvement Initiative, and the Comprehensive Care for Joint Replacement Model, among others, did not qualify as Advanced APMs. MSSP Track 2 and Track 3 ACOs, the Next-Generation ACO Model, and the recently announced Comprehensive Primary Care Plus (CPC+) model, qualify as Advanced APMs.

CMS requires Advanced APMs to strictly satisfy the rigorous qualification requirements in the MACRA, including that: (1) the APM must require participants to use certified EHR technology; (2) the APM must provide for payment for covered professional services based on quality measures comparable to those in the quality performance category under the MIPS; and (3) the APM must either require that participating APM entities bear risk for monetary losses of more than a nominal amount under the APM, or be a medical home model expanded under CMMI's Section 1115A authority.

CMS implemented a higher standard for financial risk bearing than many in the provider community had hoped. Advanced APMs must include provisions that, if actual expenditures for which the APM entity is responsible under the APM exceed expected expenditures during the performance period, CMS may: (1) withhold payment for services and/or the APM entity's eligible clinicians; (2) reduce payment rates to the APM entity and/or its eligible clinicians; or (3) require the APM entity to owe payments to CMS. While CMS acknowledged the significant investments that many MSSP ACOs have made to develop population health management capabilities and infrastructure, CMS did not believe that sort of business risk satisfied the statutory requirement in the MACRA. Consequently, only those ACOs that share financial risk under the proposed nominal amount standard (based on marginal risk, minimum loss rate, and total potential risk thresholds) qualify as Advanced APMs.

As noted above, QPs and Partial QPs that satisfy the minimum requirements for participation in an Advanced APM will be eligible for a 5% bonus from 2019 through 2024 based on the clinician's total previous year's Part B professional claims. In addition to satisfying CMS's Advanced APM criteria, QPs and Partial QPs must have a sufficient percentage of their Medicare revenue (and all-payer revenue in later years) flowing through Advanced APMs. CMS also proposed a method that considers the number of attributed Medicare patients in the Advanced APM (and all-payer patients in later years). For 2019, QPs must receive 25% of their Medicare payments through the Advanced APM or have 20% of their patients attributed through an Advanced APM. For 2019, Partial QPs must receive 20% of their Medicare payments through the Advanced APM or have 10% of their patients attributed through an Advanced APM. Partial QPs would have the option to report measures under the MIPS and be subject to a positive, negative, or neutral payment adjustment; however, they would not be eligible for the 5% incentive payment or the APM conversion factor that takes effect for 2026. The revenue and patient count thresholds for Advanced APMs increase over time and begin to consider all-payer revenue and patient counts in 2021.

CMS classified eligible clinicians for each APM entity based on the participant list as of December 31st of each QP performance period. CMS further made QP determinations at a group level. As a result, QP determinations for the group would apply to all the individual eligible clinicians who are identified as part of an Advanced APM entity (e.g., all eligible clinicians participating in a qualifying ACO). If that eligible clinician group's collective threshold score meets the relevant QP threshold, all eligible clinicians in that group would receive the same QP determination for the year. Calculations used to arrive at the QP determination are aggregated using data for all eligible clinicians participating in the Advanced APM entity during the performance period. The performance period is the full calendar year that aligns with the MIPS performance period.

CY 2018 UPDATES TO THE QUALITY PAYMENT PROGRAM: PROPOSED RULE (RELEASED JUNE 20, 2017)

On June 20, 2017, CMS released the proposed rule covering changes to MIPS and Advanced APMs participation options including requirements for 2018. Several of the major provisions propose the following: 1) Establish MIPS 2018 reporting requirements; 2) Delay the requirement to upgrade to the 2015 edition of Certified EHR Technology; 3) Increase the low-volume threshold to exclude individual MIPS eligible clinicians or groups with less than or equal to \$90,000 in Part B allowed charges or less than or equal to 200 Part B beneficiaries during a low-volume threshold determination period that occurs during the performance period or a prior period; 4) Delay the cost component of MIPS resulting in zero percent (0%) in 2020 MIPS payment year, but are soliciting feedback on keeping the weight at ten percent (10%); 5) Including the option to use facility-based scoring for facility-based clinicians, available only for facility-based clinicians who have at least seventy-five percent (75%) of their covered professional services supplied in the inpatient hospital setting or emergency department; 6) Adding virtual groups as a participation option for solo and small practices to aggregate data for a shared MIPS evaluation (discussed in more detail below); and 7) Outlines qualification criteria as a participant in an all-payer APM beginning in 2019.

The Proposed Rule offers virtual group participation in MIPS. The virtual groups would be composed of solo practitioners and groups of 10 or less, who are eligible to participate in MIPS, to join together to participate in MIPS for a performance period of a year. The virtual groups would not have geographic or practice restrictions and would report as group across all four performance categories and are expected to meet same requirements as non-virtual groups. For solo practitioners to be eligible, they must meet the definition of a MIPS eligible clinician and not be excluded from MIPS based on one of the exclusions (new Medicare-enrolled eligible clinician; Qualifying APM Participant; Partial Qualifying APM Participant who chooses not to report on measure and activities under MIPS; and those who do not exceed the low-volume threshold). In order for groups of 10 or less eligible clinicians to be part of a virtual group, the groups would need to exceed the low-volume threshold at the group level. Any group that is part of a virtual group may include eligible clinicians who do not meet the MIPS definition of an eligible clinician or may be excluded from MIPS based on one of the four exclusions.

Additionally, the Medicare Payment Advisory Commission (MedPAC) released its June 2017 report on Medicare payment policy to Congress. Part of this report focused on proposed changes to MIPS. MedPAC recommended the replacement of current measures with population-based outcome measures. The recommendations also included allowing clinicians to choose one of the following paths: 1) join an APM; 2) be measured as a group that they define; 3) be measured as a group that Medicare defines; or 4) choose not be measured at all. If clinicians chose not be measured at all, they would be subject to a set percentage reduction for all services under the physician fee schedule.

CONCLUSION

The Final Rule reflects a commitment by CMS to address the many shortcomings in the current Medicare physician payment system. Although likely to be subjected to ongoing scrutiny from the provider community, the proposed changes to the reporting and scoring structure in MIPS aim to reduce administrative burden and complexity and increase flexibility and transparency. While it is too early to tell how MIPS will ultimately impact providers, the provisions in the Proposed Rule, if implemented, would significantly improve the manner in which clinicians are evaluated by Medicare.

With respect to Advanced APMs, CMS has continued its aggressive effort to transition providers to more aggressive APMs that involve two-sided risk. Coupled with the new Track 3 ACO, the Next-Generation ACO Model, and the payment waivers and enhanced beneficiary engagement tools reserved for these advanced models, the Proposed Rule exemplifies CMS's belief that success in achieving the Triple Aim requires providers to transition to two-sided risk. Those providers that are willing to make the transition for the 2017 performance year have an opportunity to gain significant advantages under the new Quality Payment Program.

The Proposed Rule shows CMS's focus on reducing burdens and offering flexibilities to help encourage participation. This is demonstrated by providing alternative participation opportunities under MIPS and providing updates and guidance regarding APMs moving forward.

Note: For additional assistance, the American Medical Association (AMA) has introduced a short video, "[One patient, one measure, no penalty: How to Avoid a Medicare Payment Penalty with Basic Reporting.](#)" The video offers step-by-step instructions on how to report so physicians can avoid a negative 4-percent payment adjustment in 2019. The AMA website also provides links to [CMS' quality measure tools](#) and an example of what a completed 1500 billing form looks like.