
Changing the Way You Get Paid: CMS Issues Proposed Rule Implementing MACRA

[CMS-5517-P] - Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

Overview

On April 27, 2016, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule to begin implementing the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA). MACRA was bipartisan legislation signed into law in the spring of 2015 to permanently repeal the Sustainable Growth Rate (SGR), streamline quality reporting programs, and provide incentive payments for participation in advanced alternative payment models. The proposed rule released by CMS is a first step in implementing the law.

Goals: Value-Based Payments and Alternative Payment Models in Medicare

- 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016 and 50% by the end of 2018 (Note: The 2016 goal has already been achieved.)
- 85% of Medicare fee-for-service payment tied to quality or value by the end of 2016 and 90% by the end of 2018

Current System

- Fee-for-service model: paying for the quantity of services performed
- The Sustainable Growth Rate (SGR) was established in 1997 to control the cost of Medicare payments to physicians. Under the SGR, if overall physician costs exceed target Medicare expenditures, physician payments are cut across the board. Each year, Congress passed temporary “doc fixes” to postpone the SGR cuts each year.

What does MACRA do?

- Repeals the SGR
- Streamlines quality reporting programs
- Provides incentive payments for participation in advanced alternative payment models
- Gives physicians a fee increase of 0.5 percent per year in years 2016 through 2019
- Requires physicians to choose between two newly designed payment paths (From 2020 to 2025, no across-the-board fee increase will be granted as physicians will be participating in one of the two new paths)

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Comment Deadline

CMS is accepting comments on the proposed rule until June 27, 2016 at Regulations.gov. CMS will issue the final rule during the fall of 2016 and the proposed effective date of the Quality Payment Program is January 1, 2017.

Resources

[MACRA Legislation](#)

[Proposed Rule](#)

[CMS Summary of Proposed Rule](#)

[CMS Slide Presentation](#)

[MACRA Impact on Small Practices](#)

[AMA Resources](#)

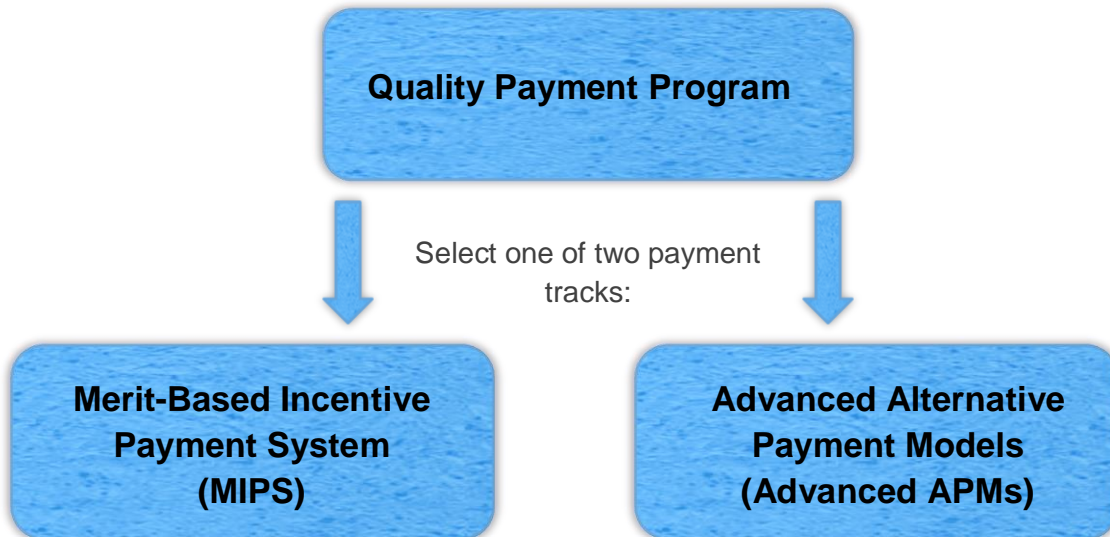
[Center for Healthcare Quality and Payment Reform](#)

[A Guide to Physician-Focused Alternative Payment Models](#)

[National Quality Forum - Measures Application Partnership](#)

How is MACRA being implemented?

CMS is implementing MACRA through rulemaking. The notice of proposed rulemaking issued on April 27, 2016 establishes an umbrella Quality Payment Program with two new pathways for payment: 1. Merit-Based Incentive Payment System (MIPS) and 2. Advanced Alternative Payment Models (Advanced APMs). If a physician makes no choice or is deemed ineligible to participate in an alternative payment model, he/she will be assigned to MIPS. **The proposed effective date for the Quality Payment Program is January 1, 2017.**



Merit-Based Incentive Payment System (MIPS)

Participation in MIPS constitutes one of two payment paths under the Quality Payment Program. MIPS streamlines the current physician reporting programs: Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier, and the Medicare Electronic Health Record (EHR) Incentive Program. **These programs will sunset at end of 2018 and MIPS will begin adjusting payments in 2019.**

Who participates in MIPS?

“MIPS eligible clinicians” include physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists who bill under Medicare Part B in year one of the program and beyond. In years three of the program and beyond, CMS may add physical or occupational therapists, speech-language pathologists, clinical social workers, clinical psychologists, dietitians, and nutritional professionals as “MIPS eligible clinicians.”

Who is excluded from MIPS?

- Clinicians newly enrolled in Medicare Part B (these clinicians are excluded for the first year)
- Clinicians that meet or exceed the low patient volume threshold (Medicare billing is less than or equal to \$10,000 AND care provided to 100 or fewer Medicare patients in one year)
- Certain clinicians participating in Advanced APMs
- Hospitals and facilities (MIPS applies only to clinicians)

MIPS Performance Categories

MIPS has four weighted performance categories:

1. Quality (50% of overall score in year one, 45% in year two, and 30% in future years) – Replaces Physician Quality Reporting System (PQRS) and some components of the Value-Based Modifier (VBM); Clinicians must report six measures (one must be a cross-cutting measure and one must be an outcome measure); Population measures are automatically calculated.
 - Specialties that do not have outcome measures or measures in “high priority” areas will be at a disadvantage under this proposed quality performance scoring methodology.
 - CMS is proposing inclusion of the following quality measure specifically related to spine treatment:
 - Functional Status Change for Patients with Lumbar Impairments (Outcome Measure): A self-report outcome measure of functional status for patients 18 years+ with lumbar impairments. The change in functional status assessed using FOTO’s (lumbar) PROM is adjusted to patient characteristics known to be associated with functional status outcomes (risk-adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality.
 - Key changes from PQRS:
 - Reporting reduced from nine measures to six measures with no domain requirements
 - Reporting emphasis on outcome measurement
2. Resource Use/Cost (10% of overall score in year one) – Replaces the cost component of the VBM; Assessment under all available resources use measures, as applicable to the clinician. There are no reporting requirements for clinicians as CMS calculates this category based on claims.
 - CMS is proposing to add 41 episode-based measures to account for differences among specialties based on conditions and procedures with high cost, high variability in resource use, or high impact conditions. CMS has worked to define “episodes” by 1. identifying a “trigger” event, 2. grouping clinically related services together during the course of the episode and 3. closing the episode after a length of time based on the typical course of treatment for that episode.
 - CMS is defining these episodes in order to look at spending patterns, to account for Medicare cost and utilization, and to estimate average payments for selected conditions/treatment in anticipation of creating bundles.
 - **CMS is proposing a spinal fusion measure including episode trigger codes and codes for services grouped into the episode. More information on the proposed spine fusion measure can be found [here](#) (click on “Method A” and “Method B” and look for the spine fusion spreadsheets.**
 - CMS plans on making refinements to its physician/patient attribution methodology starting in 2018, although this will not be in time for the 2017 reporting period, which will impact the 2019 payment adjustment.
3. Clinical Practice Improvement Activities (15% of overall score in year one) – “New” domain added to the previously existing other three; Focuses on patient-centered approach to developing incentives and policies that drives improved patient health outcomes; Clinicians must report one activity from 90+ proposed activities with additional credit for more reported activities (e.g. after hours access to care, care coordination, shared decision-making, safety checklists, etc.); Rather than requiring a full year of reporting, these activities would be performed for at least 90 days during the performance period.
4. Advancing Care Information (25% of overall score in year one) - Formerly EHR “Meaningful Use” (MU) Program and includes the same measures from MU Stage 3 and Modified Stage 2, but thresholds have been removed; Scoring based on key measures of health IT interoperability and information exchange.

- Moves away from a pass-fail program design by combining a Base Score and Performance Score into an overall composite score.
- Base Score (50 points) + Performance Score (80 points) + Bonus Point (up to 1 point) = Composite Score for this category (Earn 100 or more points to receive the full 25% in this performance category)
 - Base Score (50 points): only requires attestation or simple yes/no options for each objective measure; CMS proposes six measures for the base score: protect patient health information, electronic prescribing, patient electronic access, coordination of care through patient engagement, health information exchange, and public health and clinical data registry reporting
 - Performance Score: clinicians select the measures that best fit their practice from the following objectives: patient electronic access, coordination of care through patient engagement, and health information exchange; The Performance Score does not utilize thresholds and allows physicians to receive partial credit on measures; Physicians can also receive a bonus point for reporting to multiple public health and clinical data registries.
- No longer requires physicians to report on two measures that hindered usability: computerized provider order entry and Clinical Decision Support
- Removes clinical quality measures to streamline overall quality reporting in MIPS
- Allows group data submission and performance to be assessed as a group (as opposed to the individual clinician)
- Permits physicians to submit data for the first time through Qualified Clinical Data Registries
- Changes the scoring without changing the actual measures--the new program would only change how these measures are counted
- Retains a pass-fail element in the base performance score (Protecting Patient Information), which can make up half of the total composite score for this category. This measure requires a security risk analysis, which has historically been challenging for physicians.
- Requires new participants to start reporting under a full calendar year (instead of a 90-day reporting period)

MIPS Overall Composite Performance Score

- The four performance categories are used to calculate an overall composite performance score (0-100 point scale)
 - Scoring method accounts for:
 - weights of each performance category
 - exceptional performance factors
 - availability and applicability of measures for different categories of clinicians
 - group performance
 - special circumstances including small practices, rural practices, etc.
- The overall composite performance score will be compared to the MIPS performance threshold to determine the payment adjustment percentage for each clinician. High-scoring clinicians will get a payment bonus and low-scoring physicians will see their payments reduced.

How to participate in MIPS?

- Individual (use individual unique Tax Identification Number (TIN) and National Provider Identifier (NPI))
- Group (use a single TIN with two or more NPIs that have assigned billing to the TIN)
- “Virtual groups” will not be implemented in year one of MIPS

How to submit data to CMS for MIPS?

- Data submission depends on whether the clinician is reporting as an individual or as a group

- Data can be submitted via claims, QCDR, Qualified Registry, EHR Vendors, CMS Web Interface, and CAHPS

MIPS Performance Cycle

- Performance evaluated on an annual basis from January 1-December 31
- Performance in 2017
- Data collection in 2018
- Payment adjustments in 2019
- This continues the problem of delayed feedback for physicians.

MIPS Payment Adjustments

- Payment adjustments are based on the relationship between the overall composite performance score and the MIPS performance threshold.
- An overall composite performance score below the MIPS performance threshold will yield a negative payment adjustment; an overall composite performance score above the threshold will yield a neutral or positive payment adjustment.
- The amount of the payment adjustment depends on the degree to which the overall composite performance score exceeds or falls below the threshold and as well as the overall distribution (All payment adjustments must be budget neutral.)
- An additional bonus (not to exceed 10%) will be distributed to clinicians with exceptional performance where the overall performance composite score is equal to or greater than the 25th percentile above the performance threshold.
- Payment adjustment of up to +/- 4% in 2019
- Payment adjustment of up to +/- 5% in 2020
- Payment adjustment of up to +/- 7% in 2021
- Payment adjustment of up to +/- 9% in 2022 and beyond
- 3X Scaling Factor – The scaling process only applies to positive adjustments, not negative adjustments

Public Reporting of MIPS Data

Data reported under MIPS will be publicly reported on the CMS Physician Compare website.

[Alternative Payment Models \(APMs\)](#)

Participation in an Advanced APM constitutes the other payment path under the Quality Payment Program. Only participants in **Advanced** APMs at MACRA thresholds qualify for 5% lump sum payments.

Advanced APMs must meet the following criteria:

1. Participation in use of certified EHR technology
 - At least 50% of eligible clinicians must use CEHRT to document and communicate clinical care; the threshold will increase to 75% after the first year
2. Payment based on quality measures comparable to those in MIPS
 - No minimum number of measures or domain requirements, except that an Advanced APM must have at least one outcome measure
 - “Comparable” means any actual MIPS measures or other measures that are evidence-based, reliable, and valid
3. Either requires APM entities to be an enhanced medical home expanded under CMMI authority OR bear more than nominal financial risk for monetary losses

- Financial Risk Standard – APM entities must bear risk for monetary losses (If actual expenditures exceed expected expenditures, the APM must make direct payment to CMS, or there will be a reduction in payment rates to the APM entity, or payment will be withheld from the APM entity)
- Nominal Risk Standard – The risk APM entities bear must be of a certain magnitude (The amount of risk must be at least 4% of expected expenditures, marginal risk of at least 30% and minimum loss ratio of no more than 4%)
 - A minimum of 4% of total spending by APM Entity must be at risk of being withheld, repaid, or cut from APM payments by CMS. Using ACOs as example, this means 4% of the total cost of care for at least 5,000 patients would need to be at risk.
 - Practice investments and ongoing costs associated with Advanced APM not counted as risk

Medical Home Models

- Participants include primary care practices or multi-specialty practices that include primary care physicians and practitioners and offer primary care services
- Empanelment of each patient to a primary clinician
- Must meet at least four of the care coordination management criteria
- Requires one or more of the following if the APM entity fails to meet a specified performance standard:
 - Direct payment by the APM entity to CMS
 - Reduction in payment to the APM entity
 - Withhold payment from the APM entity
 - Reduction in an otherwise guaranteed payment
- The Medical Home Model standards only apply to APM entities with 50 or less eligible clinicians in the APM entity's parent organization
- The amount of risk must be at least:
 - 2.5% of Medicare Parts A and B revenue (2017)
 - 3% of Medicare Parts A and B revenue (2018)
 - 4% of Medicare Parts A and B revenue (2019)
 - 5% of Medicare Parts A and B revenue (2020 and beyond)

Which Current APMs will be considered Advanced APMs in 2017?

- Shared Savings Program (Tracks 2 and 3)
- Next Generation ACO Model
- Comprehensive ESRD Care
- Comprehensive Primary Care Plus
- Oncology Care Model
 - Extremely limited participation in all of these models currently

How do I become a Qualifying Advanced APM participant?

- In order to qualify, clinicians must have a certain percentage of patients or payments through an Advanced APM
- Qualifying APM participants will be excluded from MIPS AND receive a 5% lump sum bonus in 2019-2024 and higher fee schedule updates starting in 2026

Advanced APM Incentive Payment

The 2019 incentive payment is based on services provided in 2017. Lump sum bonus payments would be made 18 months later in mid-2019. CMS acknowledges that applications for many Advanced APMs will be due to CMS before this rule will be finalized.

MIPS APMs

- MIPS APM participants can improve their MIPS scores in APMs that do not meet criteria to be Advanced APMs or do not meet the revenue or patient thresholds to qualify for bonuses.
- APMs (such as an ACO) would report quality under the MIPS Quality Payment Program
- MIPS APMs will have the Resource Use/Cost component weight reduced to zero, thus exempting them from this MIPS component. The 10% that would have been assigned to Resource Use/Cost is used to increase weights for Clinical Practice Improvement Activities and Advancing Care Information weights by 5% each. As APM participation qualifies for Clinical Practice Improvement Activities, this is an advantage for participating physicians.
- CMS does not provide detail on what might qualify as a MIPS APM

Physician Focused Payment Models

Physician Focused Payment Model proposals from stakeholders, such as specialty societies, will be submitted to the Physician-Focused Payment Models Technical Advisory Committee (PTAC) that was created by MACRA. CMS proposes criteria for use by PTAC in reviewing the proposals. Payment models proposed to PTAC must be Medicare models, cannot be Other Payer models, and must be physician-focused, not other practitioners.

Financial Implications of the Quality Payment Program

- If a clinician is not in an APM, he/she is subject to MIPS adjustments
- If a clinician is participating in an APM, but not an Advanced APM, he/she is subject to MIPS adjustments and APM-specific rewards
- If a clinician is participating in an Advanced APM, he/she is excluded from MIPS adjustments, and is eligible for APM-specific rewards and the 5% lump sum bonus

Key Points

- The Quality Payment Program changes how Medicare pays clinicians
- Medicare Part B clinicians must participate in MIPS unless they are in their first year of Medicare Part B participation, or they become a qualifying Advanced APM participant through participation in Advanced APMs, or they fall below the low volume threshold
- MIPS payment adjustments will start in 2019