MACRA Proposed Rule

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Physician Quality and Alternative Payment Models

I. Overview

On April 27, 2016 the Centers for Medicare & Medicaid Services (CMS) issued a Notice of Proposed Rulemaking to implement provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA replaced Medicare's flawed Sustainable Growth Rate (SGR) payment formula with new payment methodologies centered on incentives for value-based quality care. Under MACRA, physicians and other practitioners will have two options to pursue additional financial incentives based on quality: the **Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs)**. The Proposed Rule would implement MIPS and the Advanced APM program under a new payment framework entitled the **Quality Payment Program** (QPP). The goal of the QPP is to shift more clinicians into value-based reimbursement models consistent with HHS's goal of tying 50% of Medicare payments to quality or value through APMs by 2018.

MIPS will consolidate the existing Physician Quality Reporting System, Value-Based Payment Modifier, and EHR Incentive Program with a more streamlined structure starting in 2019. For clinicians MIPS is intended to allow more flexibility for achieving positive payment adjustments, more options for reporting information, and the replacement of all-or-none standards with sliding scale measures. Importantly, the potential maximum downside risk changes from 9% in 2018 under the combination of the three expiring programs, to 4% in 2019 and 5% in 2020 under the new MIPS parameters.

As an alternative to MIPS, clinicians who participate sufficiently in Advanced APMs are exempt from MIPS and receive 5% incentive payments from 2019 through 2024 and higher fee schedule increases starting in 2026.1 Advanced APMs include CMS Innovation Center models and statutorily mandated demonstrations that have certain risk, quality, and EHR use requirements.

There is a 60-day comment period ending on June 27. A final rule is expected before the end of the Obama Administration. During the transition period to the new payment system, MACRA specifies that clinicians receive an annual 0.5% increase in Medicare fee reimbursements from 2016 through 2019.

II. Implementation Timeline

(A more detailed timeline is in Appendix A.)

Medicare Clinician Services Fee Schedule Updates:

- 2016-2019: 0.5% update to the clinician payment fee schedule
- 2020-2025: 0.0% update to the clinician payment fee schedule
- 2026 >: 0.75% for QPs in Advanced APMs; 0.25% for other clinicians

QPP Components:

- 2019: ±4% MIPS Adjustment (positive adjustments scaled in all years)
    - 5% incentive payments for QPs in Advanced APMs (through 2024);

- 2020: ±5% MIPS Adjustment
- 2021: ±7% MIPS Adjustment
- 2022: ±9% MIPS Adjustment, which continues for future years

III. Merit-Based Incentive Payment System (MIPS)

A. Program Overview

Under MACRA, MIPS participants receive a Composite Performance Score (CPS) to determine a positive or negative adjustment to the participant's Medicare payments in that year. The four weighted categories for calculating a CPS are: Quality, Cost/Resource Use, Advancing Care Information, and Clinical Practice Improvement Activities.[2] Starting in 2019 and 2020, physicians, dentists, nurse practitioners, physician's assistants, certified registered nurse anesthetists, and clinical nurse specialists will participate in MIPS as a requirement of Part B payment. Starting in 2021, the Secretary has the authority to extend MIPS to other clinical professionals, such as physical and occupational therapists, midwives, social workers, and psychologists. The Proposed Rule provides that clinicians may participate in MIPS as individuals or groups.[3]

Per the Proposed Rule, clinicians' payments under MIPS are tied to a performance year that is two years prior to the payment year. So, for example, performance in 2017 is the basis for the first year of MIPS payments in 2019.[4] CMS proposes that MIPS reporting and feedback periods be annual rather than quarterly, despite provider groups' desire for greater frequency.

B. Clinician Performance Categories:

1. QUALITY

Under the Proposed Rule, clinicians must report six individual quality measures or an appropriate specialty-specific measures set developed by CMS. Clinicians must choose one cross-cutting measure[5] and one outcome measure. If no outcome measure is appropriate to their clinical practice, they must choose another high-quality measure, i.e. a measure that relates to patient outcomes, appropriate use, patient safety, efficiency, patient experience, or care coordination.

For groups with nine or fewer clinicians, CMS will also calculate two population measures based on claims data. Groups with ten or more clinicians will have three population measures calculated by CMS. Each measure is worth ten points, for a total of 80 or 90 points, depending on group size. **Quality will be weighted as 50% of CPS in 2019, 45% in 2020, and, as required by MACRA, 30% beginning in 2021.**

2. COST/RESOURCE USE

CMS proposes to calculate resource use scores based on Medicare claims for a variety of resource use measures, including the total per capita cost measure, the Medicare Spending Per Beneficiary measure, and over 40 episode-specific cost measures.[6] Clinicians are awarded up to 10 points per cost measure, but need a certain number of patient encounters to be scored for that cost measure. **Resource use/cost will be weighted as 10% of CPS in 2019, 15% in 2020, and, as required by MACRA, 30% beginning in 2021.**

3. ADVANCING CARE INFORMATION (ACI)

This category replaces the EHR Incentives Program and Meaningful Use. ACI would be scored out of 131 possible points, but only 100 points are needed to get the maximum score. ACI scoring is divided as follows:

Base Score: The proposed ACI Base Score includes six objectives. Two are scored using a Yes/No binary value, and four use a percentage based upon a numerator and denominator reported for that measure.[7] The Base Score is out of 50 points.

Performance Score: Clinicians choose measures from three objectives: 1) Patient Electronic Access; 2) Coordination of Care Through Patient Engagement; and 3) Health Information Exchange. While these objectives have the same names as three of the Base Score objectives, the Base Score involves having certified EHR with certain defined capabilities, and the Performance Score measures clinicians' use of those capabilities. The Performance Score is out of 80 points.

Bonus Point: One bonus point is awarded for reporting to an additional public health registry beyond an immunization registry.

As required by MACRA, ACI will be weighted as 25% of CPS.

4. CLINICAL PRACTICE IMPROVEMENT ACTIVITIES (CPIA)

CPIA is focused on care coordination, beneficiary engagement, and patient safety. CMS proposes a score based on 60 total points measured over several categories. Activities that support the patient-centered medical home (PCMH), clinical practice transformation, or public health priorities are proposed to be designated as high priority and worth 20 points, while other measures would be worth 10 points. MACRA requires that clinicians in PCMHs automatically receive full credit for this category, and those in APMs automatically receive at least half credit. **As required by MACRA, CPIA will be weighted as 15% of CPS.**

C. Scoring and Payment Adjustment

The four category scores are each converted to a portion of the final CPS based upon the weight of the category. For example, because the quality score represents 50% of the CPS in 2019, a quality score of 80 (out of a maximum of 80), would be converted to score of 50 for calculating the CPS.

Payment adjustments will be based upon the performance of clinicians relative to other participants in the MIPS. MACRA provides that whether an adjustment is positive or negative depends on whether a clinician scores above or below the MIPS performance threshold, which will be the average of all CPSs for MIPS-eligible clinicians for a time period determined by the Secretary.[8]

Because MACRA requires MIPS to be budget-neutral, the size of the adjustments also depends on the variation of MIPS scores for a given performance year. Maximum negative payment adjustments are 4% of Part B payments to the clinician in 2019; 5% in 2020; 7% in 2021; and 9% in 2022 and thereafter. As noted, in the first few years of MIPS clinicians will have less downside risk than the 9% that they would face with the three programs MIPS will replace.

Positive payment adjustments track the maximum negative adjustment. Furthermore, depending on the distribution of CPS scores, positive adjustment percentages will be multiplied by a factor between 0 and 3 to achieve budget neutrality. For instance, in 2019, a positive payment adjustment could be up to 12%.

In addition, for years 2019 – 2024, MACRA provides for the payment of $500 million in additional incentive payments that are exempt from budget neutrality. The maximum payment to a clinician is an additional 10% of Part B payments. CMS proposes that clinicians with scores in the top 75% of possible or actual scores above the MIPS performance threshold during the relevant time period be eligible for this payment.[9]

IV. Advanced Alternate Payment Models (APMs)

A. Qualifying Models

Over the past decade, CMS has tested a number of APMs as new approaches to Medicare payment to "incentivize quality and value." CMS proposes that only APMs that are CMS Innovation Center models or statutorily required demonstrations may be "Advanced APMs." MACRA requires that all APMs—with the exception of CMS Innovation Center Medical Home Models—fulfill the following requirements to be considered Advanced APMs:

- **Financial Risk**: The APM must require its participants to bear a certain amount of financial risk—that is, participants must be in danger of financial penalties if their actual expenditures exceed their expected expenditures. Under the Proposed Rule, the level of risk must meet the following standards: 1) Maximum possible losses must be at least 4% of expected expenditures; 2) Clinicians must be responsible for at least 30% of excess spending; and 3) The amount by which expenditures exceed expectations before financial penalties are triggered may not exceed 4%.
- **Quality Measures**: The APM must base payments on quality measures comparable to those used in the MIPS Quality performance category. The CMS proposal provides that at least one of the measures used must have an evidence-based focus, be reliable and valid, and meet one of five other criteria set out in the Proposed Rule. At least one must be an outcome measure if there is an APM-appropriate one in the MIPS measure list.
- **Electronic Health Records**: The APM must require participants to use certified EHR technology. According to the Proposed Rule, at least 50% of clinicians in the APM must use such technology in the first performance year; and at least 75% in the second performance year and thereafter.

CMS proposes to update the list of Advanced APMs at least annually as new models qualify. The following models qualify as advanced APMs for the first performance year: 1) Comprehensive ESRD Care Model (Large Dialysis Organization arrangement); 2) Comprehensive Primary Care Plus; 3) Medicare Shared Savings Program, Tracks 2 and 3; 4) Next Generation ACO Model; 5) Oncology Care Model Two-Sided Risk Arrangement (available 2018); and 6) CMS Innovation Center Medical Home Models that have been expanded into regular Medicare (none have been expanded so far).

B. Qualifying Participants

Clinicians or entities that receive enough of their payments—or see enough of their patients—through Advanced APMs become (or their clinicians become) Qualifying Participants (QPs). The payment thresholds are established by statute, while the patient thresholds are set out in the Proposed Rule. In 2019 and 2020 those thresholds are 25% of Medicare payments or 20% of Medicare patients. In 2021 and 2022 the thresholds are 50% of payments or 35% of patients.[10] From 2023 on the thresholds are 75% and 50%, respectively.

By statute, QPs are excluded from MIPS and they receive the lump sum bonus of 5% of Part B payments from 2019 through 2024. Beginning in 2026, QPs receive a 0.75% fee schedule update, as opposed to 0.25% for non QPs.

Similar to MIPS, the performance period for determining whether a clinician is a QP is two years before the payment year. In other words, a clinician or entity's payment or patient percentages in 2017 would determine whether that clinician or entity receives a 5% payment in 2019. The 2019 payment would be 5% of Part B payments to the clinician or entity in 2018. The Proposed Rule estimates that 30,658 – 90,000 clinicians will be QPs in 2019.

C. Partial QPs and Non-Advanced APM Participants

MACRA allows a clinician to be a partial QP by meeting lower thresholds than are required of QPs. In 2019 and 2020 the partial QP thresholds are 20% of Medicare payments or 10% of Medicare patients. In 2021 and 2022 the thresholds are 40% of payments or 25% of patients. From 2023 on the thresholds are 50% and 35%, respectively. CMS proposes to permit partial QPs to opt out of their MIPS payment adjustments at any time during a performance year. Partial QPs do not receive the same financial incentives as QPs.

Participants in non-advanced APMs must participate in MIPS, but their APM participation benefits them in MIPS scoring.

D. Other Payers

The MACRA statute requires that, starting in 2021, arrangements with non-Medicare payers be permitted to count towards becoming a QP. If the "Other Payer APMs" meet criteria similar to those for advanced APMs, they will be considered "Other Payer Advanced APMs" and clinicians can become QPs based upon a combination of their Medicare and Other Payer dollars or patient counts.

V. Conclusion

By eliminating the SGR formula, the MACRA law ended years of uncertainty and budgetary political maneuvers related to how Medicare would pay physicians for their outpatient services. Congress repeatedly overrode the reductions threatened under SGR, while also adding additional quality reporting requirements and financial incentives for various activities. The MACRA legislation had broad bipartisan and physician society support for modernizing payment adjustments and quality reporting requirements into a more unified system.

Consistent with HHS's goals for moving towards more value based payments, the QPP is designed to expand the number of Advanced APMs and the number of clinicians who become QPs because of their participation in Advanced APMs with either Medicare or private payers. The overarching goal of increasing clinician accountability for their financial performance and their patients' clinical outcomes is embedded in the QPP, as is demonstrated by the greater fee schedule increases QPs will receive starting in 2026.

Moving forward, there is uncertainty about the impact and feasibility of MACRA's many provisions for individual specialties. Key questions include: what qualifies as an Advanced APM (particularly those developed by private payers), what are the thresholds for becoming a QP (particularly under the All-Payer payment or patient count methods), and what will be the yearly payment adjustments to the baseline fee schedule (particularly for the years 2020-2025 when the fee schedule update is zero, and for certain types of providers, such as primary care, some specialists, or in rural or underserved areas). Another major concern is that negative MIPS adjustments will disproportionately affect clinicians in small practices—notwithstanding CMS efforts, which include low volume exclusions from MIPS, scoring flexibility, virtual group reporting, and other measures. A further issue is what measures hospital-employed doctors will be able to submit for MIPS, and how that will affect both their payment adjustments and care coordination in the hospital setting.

In addition, while the QPP payment and quality reporting changes apply to Medicare Part B services and clinicians broadly, CMS will continue to develop, implement and expand payment models and demonstrations that will affect subgroups of clinicians and patients. For example, CMS will soon commence the Oncology Care Model, has proposed expanding the CPC Initiative into the CPC+ Initiative, and has proposed a sweeping experiment around changes to payments to Part B drugs, all of which could have significant implications for clinicians and patients. How CMS integrates and coordinates those new payment models with the QPP—and the practical implications for patients and clinicians—will potentially be an expanding logistical and administrative challenge for CMS and clinicians.

Appendix A: Year-by-Year Timeline for MACRA and QPP Payment Changes

Year	Events
2016	■ Fee schedule increase of 0.5%
2017	■ Fee schedule increase of 0.5% ■ First performance year for MIPS and Advanced APMs (for payment year 2019)
2018	■ Fee schedule increase of 0.5% ■ Final payment year for Physician Quality Reporting System, Value-Based Payment Modifier, and EHR Incentive Program
2019	■ Fee schedule increase of 0.5% ■ First payment year for MIPS ▸ Based on performance year 2017 ▸ Maximum Negative Adjustment: 4% ▸ Positive Adjustment Range: 0 – 12% ■ First payment year for Advanced APM QPs ▸ Based on performance year 2017 ▸ 5% lump sum reward for QPs (based on Medicare payments from 2018) ▸ Advanced APM participation requirements for QP status: 25% of Medicare payments (20% for partial QP) 20% of Medicare patients (10% for partial QP)
2020	■ No fee schedule increase ■ MIPS payment: ▸ Maximum Negative Adjustment: 5% ▸ Positive Adjustment Range: 0 – 15% ■ Advanced APM QPs ▸ 5% lump sum reward ▸ Advanced APM participation requirements for QP status: 25% of Medicare payments (20% for partial QP) 20% of Medicare patients (10% for partial QP)
2021	■ No fee schedule increase ■ MIPS payment: ▸ Maximum Negative Adjustment: 7% ▸ Positive Adjustment Range: 0 – 21%

	■ Advanced APM QPs ▸ 5% lump sum reward ▸ Advanced APM participation requirements for QP status: 50% of payments (40% for partial QP) AND 25% of Medicare payments (20% for partial QP) 35% of patients (25% for partial QP) AND 20% of Medicare patients (10% for partial QP)
2022	■ No fee schedule increase ■ MIPS payment: ▸ Maximum Negative Adjustment: 9% ▸ Positive Adjustment Range: 0 – 27% ■ Advanced APM QPs—No change
2023	■ No fee schedule increase ■ MIPS payment—No change ■ Advanced APM QPs ▸ 5% lump sum reward ▸ Advanced APM participation requirements for QP status: 75% of payments (50% for partial QP) AND 25% of Medicare payments (20% for partial QP) 50% of patients (35% for partial QP) AND 20% of Medicare patients (10% for partial QP)
2024	■ No fee schedule increase ■ MIPS payment—No change ■ Advanced APM QPs—No change
2025	■ No fee schedule increase ■ MIPS payment—No change ■ Advanced APM QPs ▸ No additional 5% lump sum reward incentive ▸ Advanced APM participation requirements for QP status—no change
2026 and on	■ Fee schedule increase ▸ 0.75% for QPs in Advanced APMs ▸ 0.25% for everyone else ■ MIPS payment—No change ■ Advanced APM QPs ▸ Financial incentive is larger fee schedule increase ▸ Advanced APM participation requirements for QP status—no change

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1. Clinicians who have low volume of Medicare in their practice ($10,000 or less per year and 100 or fewer Medicare beneficiaries per year), or are newly enrolled in Medicare are also exempt from MIPS for that year.

2. Certain clinicians for whom a category, such as Advanced Clinical Information, is not appropriate or measurable will have the other categories reweighted in calculating their CPS.

3. The Proposed Rule calls for performance adjustments for clinicians to be tied to NPI (National Provider Identifier), rather than TIN (Tax Identification Number) because of concerns about clinicians moving in and out of groups that bill under a TIN, which could disconnect payment adjustments from performance of individual clinicians.

4. Even though, as noted above, not all Part B clinicians participate in MIPS payment during 2019 and 2020, they all report through MIPS in 2017 in order to determine eligibility to be a Qualifying Participant in an advanced APM.

5. Under the Physician Quality Reporting System, a cross-cutting measure is defined as "a measure that is broadly applicable across multiple providers and specialties."

6. Clinicians will not have any reporting requirements related for this MIPS category since CMS will do all the calculations based upon Medicare claims data.

7. The objectives are 1) Protect Patient Health Information (Y/N); 2) Electronic Prescribing (N/D); 3) Patient Electronic Access (N/D); 4) Coordination of Care Through Patient Engagement (N/D); 5) Health Information Exchange; and 6) Public Health and Clinical Data Registry Reporting (Y/N). The Base Score is out of 50 points. An answer of Yes on the "Protect Patient Health Information" objective is required to receive any score for the ACI category.

8. MACRA sets out a special rule for the first two years of MIPS, requiring the Secretary, prior to the performance period, to set out a threshold based on a prior period. For the 2019 payment year, CMS proposes to model data from 2014 and 2015 to determine the performance threshold.

9. For payment year 2019, because there are no CPSs to use to determine the additional performance threshold, CMS is proposing to base the threshold at the 25th percentile of possible CPSs above the MIPS performance threshold.

10. Starting in 2021, non-Medicare payments and patients may count towards the target. Those entities counting non-Medicare payments and patients must still receive a certain percentage of attributable Medicare payments or patients through Advanced APMs to be QPs.

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