Akin Gump
STRAUSS HAUER & FELD LLP

Medicare Physician Fee Schedule Merit-Based Incentive Payment System and Alternative Payment Model Incentives Proposed Rule

Prepared for NRHI

Background

Just over one year after the president signed the Medicare Access and CHIP Reauthorization Act (MACRA) on April 14, 2015, the Centers for Medicare & Medicaid Services (CMS) released its long-awaited proposal detailing when and how the agency will implement reforms to the way Medicare reimburses physician services. CMS has named the new payment system the "Quality Payment Program."

Below are some questions and answers highlighting how CMS is proposing to design the various components of this new program, which include the Merit-based Incentive Payment System (MIPS) and the bonus incentives for certain "advanced" alternative payment models (APMs).

I. Overall Structure of Quality Payment Program

Q: How will physician reimbursement be impacted by the new Quality Payment Program?

A: At a basic level, the Quality Payment Program will tie Medicare Part B payments to performance. The impact on physician practices will vary based on (a) which of two payment tracks they choose – the default track called the Merit-based Incentive Payment System (MIPS), or the voluntary track for participants in certain "advanced" Medicare alternative payment models (APMs); and (b) their performance within the selected track.

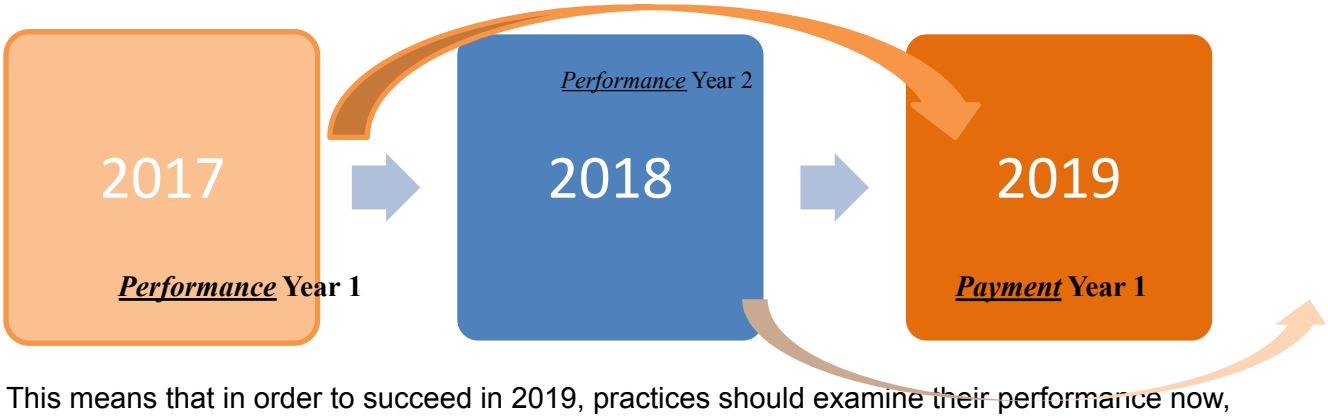
- *MIPS*: Under the MIPS, Medicare Part B payments may be adjusted upward or downward based on performance across various metrics. The MIPS is mandatory, and will apply to all practices that are not otherwise exempted by virtue of participating in an advanced APM, having too little Part B business, or being newly enrolled in the Medicare program. CMS refers to clinicians subject to MIPS as "MIPS Eligible Clinicians."

- *Advanced APMs*: Physicians that participate in certain "Advanced APMs," like risk-bearing Accountable Care Organizations (ACOs), are eligible for a separate incentive (a 5% bonus on Part B payments) and are exempt from MIPS payment adjustments. CMS refers to clinicians that qualify for the 5% bonus as "qualifying APM participants" or "QPs."

While the option to participate in an Advanced APM is a real one, CMS expects that the vast majority of clinicians will be subject to the MIPS by default. This is largely because the Advanced APM options are relatively few, and the barriers to entry can be high. Furthermore, even participants in Advanced APMs may not meet participation thresholds set by CMS (e.g., for 2019, have 50% of Medicare Part B payments flowing through APM) to qualify for the bonus.

Q: When will the Quality Payment Program begin to impact Part B payments?

A: 2019 is the first "payment year" for the Quality Payment Program. This means that in 2019, MIPS payment adjustments will begin to impact Part B payments for MIPS-eligible practices, and the 5% bonus for advanced APM participants will be payable. But, it is important to recognize that performance from a prior year will dictate payment impact in 2019. Specifically, CMS says it intends to base 2019 MIPS payment adjustments on a physician's (or group's) performance during calendar year 2017.



This means that in order to succeed in 2019, practices should examine their performance now, in advance of January 1, 2017. Practices can do this by looking at their Quality and Resource Use Reports (QRURs), distributed by CMS last fall, which illustrate each practice's performance on the quality and cost metrics used in the current physician value-based payment modifier (VM) program.

Also, in determining whether a clinician is a participant in an Advanced APM, CMS will look to a performance period that is two years prior to the year the bonus is payable. In other words, clinicians must participate in an advanced APM during 2017 (and be listed on that APM entity's participant list as of December 31, 2017) in order to be considered a qualifying APM participant ("QP") that receives a 5% bonus in 2019.

Q. What does MACRA do to promote participation in APMs?

A. MACRA includes new payment incentives that are designed to encourage physicians to participate in APMs. Specifically, physicians who participate significantly in certain types of "Advanced APMs" can earn a lump sum bonus payment of 5% of their estimated aggregate Part B PFS payments in a given year. Physicians who participate in these Advanced APMs to a sufficient degree are also excluded from the MIPS.

As described in more detail below, MACRA also builds incentives for APMs into MIPS. APMs will be subject to MIPS if they do not qualify as "Advanced APMs," or if they qualify as an "Advanced APM" but the participants fail to meet certain participation thresholds. APMs in MIPS, called "MIPS APMs," will receive favorable treatment for purposes of scoring.

Finally, MACRA puts in place a process for physicians and other stakeholders to design and recommend new models. A new Technical Advisory Committee is tasked with reviewing and making recommendations on the creation of new "Physician-Focused Payment Models," including models for specialist physicians. This includes a process for transparency and

stakeholder input regarding the Technical Advisory Committee's recommendations to CMS regarding new APMs.

II. Merit-Based Incentive Payment System

a. MIPS Overview

Q. What is the MIPS?

A. The MIPS is the new, unified Medicare physician payment system that will adjust Part B payments to physicians and other eligible professionals based on performance beginning in calendar year 2019. The MIPS combines elements of the three current Medicare fee-for-service physician quality programs:

- the Physician Quality Reporting System (PQRS);
- the Value-Based Payment Modifier (VM); and
- the "Meaningful Use" Electronic Health Record (EHR) Incentive Program

Using this methodology, physicians will receive a composite score for each performance period, which will be compared to a performance threshold defined in advance. Depending on whether their composite score falls above or below the performance threshold, physicians will receive a positive or negative adjustment to their Part B payments. For 2019, the MIPS adjustment will be plus or minus 4%, and will gradually increase to plus or minus 9% in calendar year 2022 and beyond. Physicians who are "exceptional" performers would also be eligible for an additional bonus payment.

CMS states that its strategic goal for developing the MIPS is to advance a program that is meaningful, understandable, and flexible for participating clinicians. To accomplish this goal, the agency indicates that it has made an effort in the Proposed Rule to remove as much administrative burden as possible from MIPS eligible clinicians and their practices while still providing meaningful incentives for high-quality efficient care.

Q. Who will be subject to Medicare Part B payment adjustments under the MIPS?

A. The MIPS would apply to "eligible clinicians" who bill for Part B services under the PFS, including physicians and the following types of non-physician practitioners: physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists. The following categories of clinicians would be excluded from the MIPS reporting and payment adjustments:

- New Medicare-enrolled eligible clinicians;
- Qualifying APM participants (QPs) and partial qualifying APM participants (Partial QPs) (discussed in more detail in the APM section below); and
- Otherwise eligible clinicians who treat a low-volume of Medicare beneficiaries.

Under the Proposed Rule, eligible clinicians would have the option of having their performance evaluated individually or collectively as part of a group. CMS estimates that between 687,000

and 746,000 eligible clinicians would have their Medicare payment adjusted, positively or negatively, under the MIPS in 2019.

Q. What are the MIPS performance categories under which clinicians will be evaluated?

A. MACRA requires CMS to evaluate MIPS eligible clinicians under four performance categories: quality; resource use; clinical practice improvement activities; and use of electronic health records (EHRs). The following pie chart summarizes the MIPS performance categories and how they are weighted for the 2019 MIPS payment adjustment (2017 performance period):

MIPS Performance Categories and 2019 Weightings

After 2019, the resource use performance category will grow in weight, and will be weighted at 15% in 2020, and at 30% in 2021 and each year thereafter. The weight of the quality

performance category will decrease relative to the increase in the resource use performance category, such that it will be weighted at 30% in 2021 and each year thereafter.

Q. How would CMS collect data from clinicians under each of the performance categories?

A. MIPS eligible clinicians would be required to submit data on measures and activities for the quality, clinical practice improvement, and advancing care information performance categories. Resource use would be measured using administrative claims data, so clinicians are not required to submit data to CMS for purposes of that performance category.

In addition to allowing individual claims reporting and group reporting through the CMS Web Interface, CMS is proposing to allow MIPS eligible clinicians flexibility in selecting third party intermediaries to collect or submit data on quality, advancing care information, and clinical practice improvement activities on their behalf. Specifically, MIPS eligible clinicians can use:

- Qualified registries
- Qualified Clinical Data Registries (QCDRs)
- Health IT Vendors that obtain data from a clinician's certified EHR technology, and CMS-approved survey vendors for CAHPS for MIPS

CMS is proposing to allow clinicians to use multiple mechanisms to report data (e.g., use a QCDR to report quality data and an EHR vendor to submit data on Clinical Practice Improvement Activities).

Q. What is CMS doing to incentivize the use of QCDRs?

A. CMS is proposing to create opportunities for QCDRs to report new and innovative quality measures, subject to CMS review and approval. In addition, several of the proposed clinical practice improvement activities emphasize QCDR participation. Finally, as noted above, CMS is proposing to allow QCDRs to submit data on all MIPS performance categories.

Q: Is CMS proposing to incorporate all-payer data?

A. Yes. CMS is proposing to include all-payer data for the QCDR, qualified registry, and EHR submission mechanisms in order to create a more complete picture of each MIPS eligible clinician's scope of practice, and provide more access to data about specialties and subspecialties not currently captured in PQRS. Under this proposal, the QCDR, qualified registry, or EHR submission must contain a minimum of one quality measure for at least one Medicare patient. CMS acknowledges that while it would like to incorporate all-payer data for all reporting mechanisms, certain reporting mechanisms (e.g., claims and CMS Web Interface) are limited to Medicare Part B data.

b. Quality Performance Category

Q. What quality measures will CMS use in the MIPS?

A. For the first year of MIPS, CMS is proposing to maintain a majority of previously implemented measures in PQRS for inclusion in the list of MIPS measures. Like under PQRS, MIPS eligible clinicians would select their quality measures from a list of all MIPS measures or from a set of specialty-specific measures. CMS is also proposing to apply three claims-based

population measures: an acute conditions composite, a chronic conditions composite, and the all-cause hospital readmissions measure.

A final list of quality measures would be published by November 1 of the year preceding the performance year – i.e., by November 1, 2016 for the first MIPS performance period. To develop this list, CMS is proposing to continue its annual "Call for Quality Measures" as a way for clinician organizations and other relevant stakeholders to submit quality measures for consideration under the MIPS.

Q. What are the reporting obligations under the Quality performance category?

A. Under CMS's proposed approach, MIPS eligible clinicians would be required to report a minimum of six measures, including one cross-cutting measure and at least one outcome measure (or other high priority measure if no outcome measure is applicable). CMS is proposing to remove the current PQRS requirement for measures to span across multiple National Quality Strategy domains. MIPS eligible clinicians would not have to report on the claims-based population measures, as these would be assessed using claims data.

Reporting on Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys will not be mandatory under the MIPS. Rather, CMS is proposing to allow registered groups of 2 or more MIPS eligible clinicians to voluntarily elect to participate in the CAHPS for MIPS survey. This would count as either a cross-cutting measure and/or a patient experience measure.

Q. How will CMS score quality performance?

A. For each measure selected, CMS will assign a score of 1-10 points based on performance as compared to a historical benchmark (2 years prior to performance year). Clinicians can earn bonus points by reporting on "high priority" measures – i.e., outcomes, patient experience, appropriate use, patient safety – and/or by using an EHR to capture and report quality information ("end-to-end electronic reporting"). The measures are averaged (total points earned / total points possible) to get a single score.

c. Advancing Care Information Category

Q. What are the reporting obligations under the Advancing Care Information performance category?

A. Under the Advancing Care Information performance category, which would replace the expiring EHR "meaningful use" program, MIPS eligible clinicians must demonstrate use of certified EHR technology by reporting on a set of objectives and measures. CMS is proposing to remove two objectives – Clinical Decision Support and Computerized Provider Order Entry – and their corresponding measures, from the requirements. Clinicians would be able to submit performance category data through qualified registry, EHR, QCDR, attestation, and CMS Web Interface methods.

Q. How will CMS score performance?

A. CMS is proposing a departure from the current "all or nothing" approach in the existing EHR Incentive Program. Instead, CMS is proposing to allow clinicians to receive partial credit (a "base score") for simply reporting on a measure, even if the clinicians do meet performance thresholds. Additional points (1-10) would be awarded to this base score according to how

clinicians perform on specific measures. Clinicians would also be eligible to receive a bonus point for reporting immunization and other data to a public health registry.

d. Clinical Practice Improvement Activities (CPIA) Category

Q. What are the obligations under the CPIA performance category?

A. For the CPIA category, clinicians would select from an inventory of more than 90 activities that relate to care coordination, patient safety, beneficiary engagement, expanded practice access, population health and other areas. Examples include participation in a QCDR, collection of patient experience and satisfaction data, participation in the CMS Transforming Clinical Practice Initiative, and certain activities through Quality Improvement Organizations. The full inventory of clinical practice improvement activities is included as Table H of the Proposed Rule.

Q. How will clinicians report CIPA to CMS?

A. Clinicians would be able to submit clinical practice improvement activity data using the qualified registry, EHR, QCDR, CMS Web Interface, or attestation mechanisms. For the 2017 performance year (2019 payment year), all MIPS eligible clinicians or groups, or the third party entities reporting on their behalf, would designate a "yes" or "no" response for activities in the CPIA inventory.

Q. How will CMS score CPIA performance?

A. CMS is proposing to measure completion of CPIAs, rather than measuring performance within any CPIA, because it lacks any baseline data for the various CPIAs. Not all activities, however, will be weighted equally. CMS is proposing to assign each activity a weight of "High" or "Medium." Activities with a high weight would include those that CMS believes are aligned with CMS national priorities and programs such as the Quality Innovation Network-Quality Improvement Organization (QIN/QIO) the Comprehensive Primary Care Initiative, and the Transforming Clinical Practice Initiative. Other activities would be assigned a medium weight.

To achieve the highest potential score for this category, clinicians would need to report three high-weighted activities (20 points each) or six medium-weighted activities (10 points each), or some combination of high and medium weighted activities to achieve a total of 60 points. Small and rural practices would have a lower point threshold to receive full credit under the performance category. CMS is proposing to require clinicians to perform CPIAs for at least 90 days during the performance period to receive credit for the activity.

As required by statute, clinicians participating in a patient centered medical home or other APM during the performance period will receive a favorable score in the CPIA performance category. A certified PCMH will automatically receive the highest potential score under the CPIA performance category. CMS is proposing to apply this to any nationally-recognized accredited patient-centered medical home, a Medicaid Medical Home Model, or a medical home model expanded by the Innovation Center. AMPs would automatically receive half of the highest potential score, and therefore would need to perform fewer additional CPIAs to achieve the highest score.

e. Resource Use

Q. How will CMS measure resource use?

A. CMS is proposing to measure clinicians on both total cost and episode-based measures. For the 2017 MIPS performance period, CMS proposes to utilize the following resource use measures:

- *Total Per Capita Cost*. The total per capita cost measure is a global measure of all Medicare Part A and Part B (but not Part D) expenditures during the performance period. Beneficiaries would be attributed to MIPS individual clinicians or groups for purposes of this measure based on where the beneficiary receives the plurality of primary care services (e.g., E&M and care coordination services).

- *Medicare Spending per Beneficiary*. The MSPB measures Part A and Part B (but not Part D) spending that relates to an inpatient hospital admission. MIPS eligible clinicians or groups with the plurality of claims for Part B services during the inpatient hospitalization that triggers the episode would be assigned to the MSPB episode for that patient.

- *Episode-Based Measures*. Episode-based measures encompass Part A and Part B (but not Part D) expenditures related to a "triggering" condition or procedure. Physician groups have received feedback on their performance on episode-based measures through Supplemental Quality and Resource Use Reports; however, to date, these measures have not been used for payment adjustments through the Value Modifier program. The list of over 40 proposed episode-based measures is found on Tables 4 and 5 of the Proposed Rule.

Q. How will CMS score resource use?

A. CMS is proposing to assign 1 to 10 points for each measure, based on clinicians' performance compared to a benchmark. CMS would establish a benchmark for each measure that would be based on actual experience during the performance period (i.e., the 2017 MSPB benchmark would be set based on 2017 data). CMS would therefore not be able to publish, and clinicians therefore would not know, the actual benchmarks against which performance will be measured in advance of a performance period. CMS is proposing to publish the benchmark-setting methodology in a final rule prior to the start of a performance period, and also to continue to provide performance feedback with information on clinicians' relative performance.

f. Scoring and payment adjustments

Q. How will performance scores in the various performance categories translate into a payment adjustment?

A. CMS would generate a single MIPS composite performance score of 0 to 100 based on performance across the 4 weighted performance categories. That score would be compared to a MIPS performance threshold to determine the adjustment percentage each eligible clinician will receive. Scores falling below the performance threshold would trigger a negative rate adjustment, and scores above the threshold would trigger a positive rate adjustment. Scores equaling the threshold would not trigger any adjustment. CMS would apply the adjustment percentage to Part B items and services furnished by the MIPS eligible clinician or group. For 2019, the adjustment percentage is set at +/- 4%. The actual upward adjustments may be higher or lower, depending on tweaks CMS may have to make to ensure that total upward adjustments equal total downward adjustments (i.e., are "budget neutral").

Q. How will CMS set a performance threshold?

A. Prior to each performance period, CMS would establish and publish a performance threshold. For 2019, CMS proposes to consider historic data (from 2014 and/or 2015) to set a threshold at a level where it would expect half of clinicians to exceed the threshold, and half to fall below it.

Q. How will CMS reward "exceptional" performers?

A. MACRA creates a bonus pool of $500 million per year, from 2019 to 2024, to fund additional upward adjustments of up to 10% for exceptional performance. CMS is proposing to establish an "additional performance threshold" at the 25th percentile of the range of possible composite scores above the regular performance threshold.

Q. Will CMS make performance data available for review?

A. Yes. CMS will provide confidential performance feedback to clinicians through a web-based portal, and will also make some performance data available to the public through the Physician Compare website (either on the public-facing profile page of from a downloadable databse).

III. Incentives for Participation in Advanced APMs

Q. When will an APM be considered an Advanced APM?

A. Not all APMs will be considered Advanced APMs. MACRA sets specific guidelines on which payment models will qualify.

First, to be considered an Advanced APM, the APM must be a:

- Center for Medicare and Medicaid Innovation (CMMI) model;
- Medicare Shared Savings Program ACO;
- demonstration under the Health Care Quality Demonstration Program; or
- other demonstration required by federal law.

Second, to be considered an Advanced APM, the APM must meet three statutory criteria:

1) The APM must require participants to use certified EHR technology

   CMS is proposing to adopt the specifications from within the current regulatory definition of certified EHR technology. CMS is also proposing that in order to meet this criteria, and APM must require at least some minimum threshold of eligible clinicians (or each hospital if the hospital is the APM participant) to use the certified health IT functions to document and communicate clinical care with patients and other health professionals. For the first QP Performance Period (2017), the threshold is 50%. For the second performance period (2018), the threshold would be 75%.

2) The APM must provide for payment for covered services based on quality measures comparable to measures under the MIPS quality performance category.

   CMS' proposal seeks to ensure that APMs have the latitude to base payment on quality measures that meet the goals of the model and assess the quality of care provided to the population of patients that the APM participants are serving. As such, CMS is not limiting APMs to a specific list of measures, nor requiring a minimum number of

measures. Instead, CMS is proposing that an APM satisfies this criterion if it bases payment on:

- ∞ At least one of the following types of measures, provided that they have an evidence-based focus and are reliable and valid:
    - ○ Any of the measures from the annual list of MIPS quality measures;
    - ○ Quality measures endorsed by a consensus-based entity;
    - ○ Quality measures developed under section 1848(s) of the Social Security Act;
    - ○ Quality measures submitted in response to the MIPS call for quality measures; or
    - ○ Any other quality measure that CMS determines (e.g., measures approved through an Innovation Center quality measure review process; QCDR measures) to have an evidence-based focus and be reliable and valid.

  And

- ∞ At least one outcome measure, provided that an appropriate measure is available on the MIPS list of measures for that specific QP Performance Period, determined at the time the APM is first established.

3) The APM must either require that participating entities bear risk for monetary losses of more than a "nominal amount" under the APM, or be a Medical Home Model expanded under section 1115A(c) under the Social Security Act.

   CMS proposes a complex three-part assessment of whether entities bear more than a nominal amount of risk for losses, which is designed to test whether the entity would actually be motivated by the risk to drive for better performance. At a basic level, under the proposal a minimum of 4% of total spending by the APM Entity must be at risk of being withheld, repaid, or cut from APM payments by CMS. Using ACOs as an example, this means that at least 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 forming and operating the APM would not count as risk.

   Medical Home Models would be subject to their own unique nominal amount standard. For these models, "nominal amount" standards would be a percentage of Part A and B revenue that the Entity would owe or have to forego under the Model. In 2019, the amount would be 2.5% of total Medicare revenue. The percentage would increase incrementally each year until it reaches 5% in 2020, after which it will remain fixed at 5%. Unlike other Advanced APMs, Medical Homes Models may count as losses the potential loss of additional payments the APM participants are receiving or have the potential to receive, such as monthly care management payments.

APMs meeting these three criteria will be considered Advanced APMs.

Q. Which of the current APMs would qualify as Advanced APMs?

A. CMS lists 24 current APMs and identifies which of those APMs, under its proposed criteria, would be Advanced APMs for the first QP Performance Period. CMS identified 5 current models that would qualify:

1) Oncology Care Model (two-sided risk arrangements only);
2) Medicare Shared Savings Program ACOs (two-sided risk arrangements only);
3) Next Generation ACO Model;
4) Comprehensive Primary Care Plus; and
5) Comprehensive ESRD Care (two-sided risk arrangements only).

CMS will post an official determination of which APMs would meet the final Advanced APM criteria prior to the beginning of the first QP Performance Period. The agency also acknowledged that deadlines to apply for Advanced APMs may have passed by the time the final list is posted.

Q. How can participants in an Advanced APM earn the 5% bonus?

A. CMS is proposing to award the 5% bonus based on the degree of participation by eligible clinicians, and not on clinician performance on quality or other metrics. In other words, an APM Entity whose clinicians perform poorly on quality metrics or that fails to meet spending benchmarks would still receive the 5% bonus if participation levels are met, though it may be subject to other penalties built into the APM (e.g., shared losses for a poor performing ACO).

Degree of participation is measured by the amount of payments attributable to Part B (or, beginning in 2021, payments from all payers) for covered professional services furnished though the APM Entity, measured as a percentage of total Part B revenue. MACRA also authorized CMS to use patient count in lieu of payment amounts. CMS is proposing to calculate participation under both methods, and use the method that is more favorable to the APM Entity.

MACRA sets payment thresholds ("QP Payment Amount Thresholds") that increase over time. CMS is proposing to also establish patient count thresholds ("QP Patient Count Thresholds") that similarly increase over time. The thresholds can be met by considering only Medicare payments and patients ("Medicare Option"), or, beginning in 2021, by considering payments and patients from all payers ("All-Payer Combination Option"). Only Medicare Part B covered professional services under the PFS will count toward for purposes of calculating percentages.

Q. What happens to Advanced APM participants that fail to meet participation levels?

A. If participation levels are within a certain range of the QP Payment Amount Thresholds (5-25%, depending on year) or QP Patient Count Thresholds (10-15%, depending on year), the participants in the Advanced APM will be considered Partial QPs. While these Partial QPs will not be eligible to receive the 5% bonus, but they would have an opportunity to decide whether they wish to be subject to a MIPS payment adjustment, which could be positive or negative.

Q. What data will CMS look at when determining whether participants are in an Advanced APM and earn the 5% bonus?

A. CMS is proposing to align the performance period for QPs (QP Performance Period) with the MIPS performance period. This means that calendar year 2017 would be the QP Performance Period for the 2019 payment year. CMS is proposing to make the QP determination at a group level.

Q. What is the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and how will it contribute to development of new payment models?

A. The PTAC, established under MACRA as an independent committee comprised of 11 members, will accept proposals from stakeholders on new Physician-Focused Payment Models (PFPMs), evaluate those proposals, and make recommendations to CMS on whether a proposed PFPM meets criteria established by CMS. CMS is not required to test models recommended by the PTAC, but stated that it "would give serious consideration to proposed PFPMs recommended by the PTAC."

In the Proposed Rule, CMS proposes criteria for use by PTAC in reviewing the proposals. These criteria broadly include value-based payment principles, care delivery improvements, and improved use of health information technology to inform care.

The PTAC recently met to discuss a process for soliciting stakeholder submissions, reviewing the submissions, and making recommendations to CMS, and is seeking comment on that process. The PTAC said it intends to issue a request for proposals, along with detailed submission criteria, once CMS finalizes the PFPM criteria in a final rule.

IV. Comments on the Proposed Rule

Q. What is the public comment process?

A. NRHI will work with members to develop a comment letter on the Proposed Rule. The deadline for submitting comments is **June 27, 2016.**