Holland & Knight

MEMORANDUM

Date: May 4, 2016

From: Miranda Franco, Senior Public Affairs Advisor

Re: Medicare Proposes Sweeping Changes to Physician Payments

On April 27, the Centers for Medicare and Medicaid Services (CMS) released the highly-anticipated CMS proposed rule to implement major Medicare physician payment reform provisions included in the *Medicare Access and CHIP Reauthorization Act* (MACRA).

MACRA repealed the Medicare sustainable growth rate (SGR) formula and directed the Secretary to implement reforms to tie physician payment updates to quality, value, and participation in alternative payment/delivery models. The law fundamentally changed how Medicare pays clinicians who participate in the program and established two tracks for Medicare reimbursement.

More specifically, MACRA mandates the development of the Merit-based Incentive Payment System (MIPS) to replace existing physician quality programs (the Physician Quality Reporting System (PQRS), the Value-Based Modifier, and the Electronic Health Records Incentive (Meaningful Use) Program) beginning January 1, 2019.

Under MACRA, the MIPS quality measure list must be released by November 1, 2016. MACRA also mandates incentives for providers to participate in alternative payment models (APMs) that focus on coordinating care, improving quality, and reducing costs; the Secretary must establish criteria for physician-focused APMs, including models for specialist physicians, by November 1, 2016.

The proposal is scheduled for publication in the Federal Register on May 9. **Comments are due at 5:00 ET on June 27.**

Highlights of the proposed rule include:

- Establish a new approach to quality reporting that seeks to streamline and simplify the disparate PQRS, Meaningful Use, and Value-Based Payment Modifier programs into a single Merit-Based Incentive Payment System (MIPS);
- Remove the "all-or-nothing" scoring approach and add much-needed flexibility to quality reporting;
- Set 2017 as the first performance measurement year for the new MIPS; and
- Detail criteria for qualification as an alternative payment model participant (APM), including eligibility for future incentive payments.

Key provisions of the proposed rule include:

Merit Based Incentive Program (MIPS)

All physicians—with a few exceptions—will report through MIPS in the first year of the program. That data will then be used by CMS to determine which providers met the requirements for the APM track. Physicians are not locked into their choice—they can switch between MIPS and APM annually.

Performance Period: Full calendar year (January 1 through December 31) reporting with, CY 2017 proposed as the first performance period on which CMS plans to base the CY 2019 payment adjustment.

Eligibility: Eligible clinicians (as opposed to "eligible professionals," or EPs, per the MACRA) include physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNS), certified registered nurse anesthetists (CRNAs), and groups that include such physicians.

CMS has authority to expand the definition of MIPS-eligible clinicians to include additional eligible clinicians through rulemaking in future years and may do so to other clinicians who are currently reporting to PQRS.

MIPS Eligible Clinician Identifier: MIPS eligible clinicians have the flexibility to submit information individually or via a group. CMS will allow the use of both Taxpayer Identification Number (TIN) and National Provider Identifier (NPI) identifiers in MIPS. Clinicians can choose to report at either the TIN or the NPI level, as long as the organization or individual is consistent in how the information is submitted across all performance categories.

Virtual groups will not be implemented in the first year.

Exclusions: MIPS contains numerous proposals exempting certain subsets of providers from MIPS participation including: 1) Medicare newly enrolled (first year) clinicians; 2) Clinicians below the low-volume threshold*;* and 3) Certain participants in Advanced APMs.

A low-volume threshold was proposed for MIPS eligible clinicians as having Medicare billing charges less than or equal to $10,000 and provides care for less than 100 Part-B Medicare beneficiaries. Additionally, CMS proposed to define non-patient-facing MIPS eligible clinicians as clinicians or groups that bill 25 or fewer patient-facing encounters during a performance period. CMS will not require non-patient-facing MIPS eligible clinicians to report a cross-cutting measure. Of note, clinicians who furnish services in Rural Health Clinics (RHC) and Federally Qualified Health Clinics (FQHC) would be required to participate in MIPS if they furnish services under the Physician Fee Schedule.

MIPS does not apply to hospitals or facilities.

Performance Categories & Scoring:

As outlined in MACRA, the proposal would consolidate three currently disparate Medicare quality programs into MIPS: (1) the Physician Quality Reporting System; (2) the Value-Based Modifier Program; and, (3) the Electronic Health Records Incentive (Meaningful Use) Program. CMS proposes that eligible clinicians receive a composite score relative to their performance in each of four categories. Quality measures for these core domains will be selected annually, with the data regarding clinician performance on the measures made available via the Physician Compare website.

Quality (50 percent of total score in year 1; replaces the Physician Quality Reporting System and the quality component of the Value Modifier Program): For this category, eligible clinicians would report six measures versus the nine required under the Physician Quality Reporting System (PQRS). This category gives clinicians reporting options to choose from to accommodate differences in specialty and practice, with an emphasis on outcome measurement.

CMS also cites the ongoing work of the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to assess the issue of risk adjustment for socioeconomic status (SES) on quality measures pursuant to the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), with its report to Congress due by October 2016. CMS notes that it "will closely examine the recommendations issued by ASPE and incorporate them, as feasible and appropriate, in future rulemaking."

Advancing Care Information (25 percent of total score in year 1) (formerly EHR Meaningful Use): For this category, clinicians would choose to report customizable measures that reflect how they use technology in their day-to-day practice, with a particular emphasis on interoperability and information exchange. Unlike the existing reporting program, this category would not require all-or-nothing EHR measurement or redundant quality reporting. Further, CMS proposes to reduce the number of quality reporting measures from 18 to 11 and remove the requirement to report on two measures that cross-cut two or more National Quality Forum (NQF) domains---participants will no longer be required to report on Clinical Decision Support [CDS] and the Computerized Provider Order Entry [CPOE] measures. However, under an alternate proposal CMS offered they could be included.

CMS is proposing that the score for the advancing care information performance category would be comprised of a score for participation and reporting, referred to as the "base score," and a score for performance at varying levels above the base score requirements, referred to as the "performance score."

Clinical Practice Improvement Activities (CPIA) (15 percent of total score in year 1): This category would reward clinical practice improvements, such as activities focused on care coordination, beneficiary engagement, and patient safety. Clinicians may select activities that match their practices' goals from a list of more than 90 options. In addition, clinicians would receive credit in this category for participating in Alternative Payment Models and in Patient-Centered Medical Homes.

Cost (Resource Use) (10 percent of total score in year 1): For this category, the score would be based on Medicare claims, meaning no reporting requirements for clinicians. This category would use 40 episode-specific measures to account for differences among specialties.

Use of CEHRT (certified electronic health record technology) and QCDRs : CMS seeks input on requiring third party vendors such as Health IT Vendors, QCDRs and qualified registries to have the capability to report data for all performance categories.

Composite Performance Score (CPS) under MIPS:

The four performance category scores (quality, resource use, CPIA, and advancing care information) would be aggregated into a MIPS composite performance score (CPS). The MIPS CPS would be compared against a MIPS performance threshold. The CPS would be used to determine whether a MIPS eligible clinician receives an upward payment adjustment, no payment adjustment, or a downward payment adjustment as appropriate.

Clinician Feedback Reports:

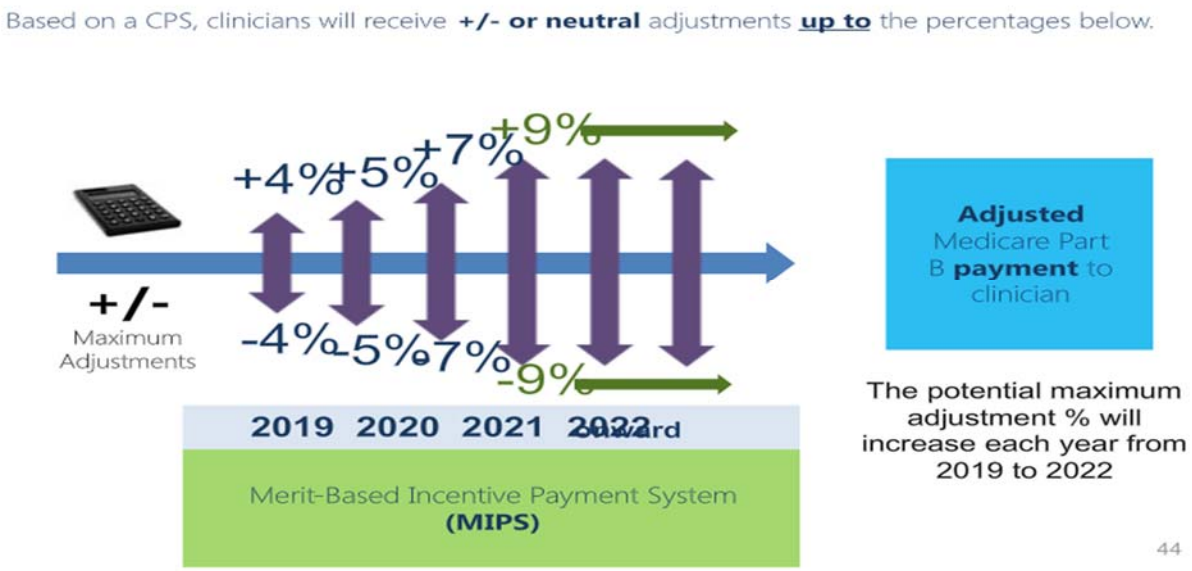
CMS seeks feedback on the frequency of performance feedback reports, whether CPIA and Advancing Care Information performance categories should be included, and data fields that should be included in the performance feedback reports as the program evolves.

CMS proposes to make performance feedback available through a CMS designated system (e.g. a web-based portal). CMS also proposes to leverage additional mechanisms, including health IT vendors, registries, and QCDRs to help disseminate information to clinicians.

MIPS Adjustments:

The law requires MIPS to be budget neutral. Therefore, clinicians' MIPS scores would be used to compute a positive, negative, or neutral adjustment to their Medicare Part B payments. In the first year, depending on the variation of MIPS scores, adjustments are calculated so that negative adjustments can be no more than 4 percent, and positive adjustments are generally up to 4 percent, with additional bonuses for the highest performers.

Per the law, both positive and negative adjustments would increase over time. Additionally, in the first five payment years of the program, the law allows for $500 million in an additional performance bonus that is exempt from budget neutrality for exceptional performance. This exceptional performance bonus will provide high performers a gradually increasing adjustment based on their MIPS score that can be no higher than an additional 10 percent. As specified under the statute, negative adjustments would increase over time, and positive adjustments would correspond. The maximum negative adjustments for each year are: 2019 - 4%; 2020 - 5%; 2021 - 7%; 2022 and after 9%.



Advanced Alternative Payment Models (APMs)

Three Components for APM Policies: CMS proposes to define three structural components for APM policies: (1) the Advanced Alternative Payment Model (Advanced APM), which is a payment and/or delivery model aimed to improve care delivery; (2) the Advanced APM Entity, which is the entity participating in the Advanced APM; and (3) the eligible clinician, who is a participating provider in an Advanced APM and may be determined to be a qualifying APM professional (QP).

APM Incentive Payments:

From 2019 through 2024, Qualifying APM Professionals (QPs) would receive a lump sum payment equal to 5 percent of the estimated aggregate payment amounts for Part B services. Beginning in 2026, payment rates under the Physician Fee Schedule (PFS) will be updated by the 0.75 percent qualifying APM conversion factor. Eligible clinicians who are QPs for a year are also excluded from MIPS for that year. This QP determination is made for one calendar year at a time. To qualify for incentive payments, clinicians would have to receive enough of their payments or see enough of their patients through Advanced APMs.

CMS is aware that the distribution of APM Incentive Payments could disadvantage MA plans relative to Medicare FFS by changing payment rates for health plans in a given area based on the aggregate APM incentive amounts paid to eligible clinicians in the area. The agency will address this issue in the 2019 Advance Notice and Rate Announcement for that program.

Advanced APM Requirements:

This rule proposes two types of Advanced APMs: Advanced APMs and Other Payer Advanced APMs. To be an Advanced APM, an APM must meet three requirements: (1) require participants to use certified EHR technology; (2) provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of MIPS; and (3) be either a Medical Home Model or bear more than a nominal amount of risk for monetary loss. The requirements for an Other Payer Advanced APM are virtually the same, but these APMs are intended to be a commercial or

Medicaid APMs. In addition, CMS is proposing to notify the public of which APMs will be Advanced APMs prior to each QP Performance period.

Advanced Alternative Payment Models:

Under the agency's criteria for payment models to be eligible for the APM track—the Bundled Payments for Care Improvement (BPCI) Initiative, the Comprehensive Care for Joint Replacement (CJR) Model, and Track 1 of the Medicare Shared Savings Program (MSSP) all will not qualify. Notably, the rule does not address whether CMS will allow Track 1 ACOs to switch MSSP tracks mid-participation agreement to join an Advanced APM.

The proposed rule includes a list of models that would qualify under the terms of the proposed rule (as they all require downside risk) as Advanced APMs. These include:

• Comprehensive ESRD Care Model (Large Dialysis Organization arrangement)

• Medicare Shared Savings Program—Track 2

• Medicare Shared Savings Program—Track 3

• Oncology Care Model Two-Sided Risk Arrangement (available in 2018)

• Next Generation ACO Model

• Comprehensive Primary Care Plus (CPC+)

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.

Medical homes must meet the conditions for at least four of these criteria: (1) planned chronic and preventive care coordination, (2) patient access and continuity of care, (3) risk-stratified care management, (4) coordinated care across a medical neighborhood, (5) patient and caregiver engagement, (6) shared decision-making, and (7) payment arrangements in addition, or substitution for Fee For Service (FFS) payments.

CMS will continue to modify models in coming years to help them qualify as Advanced APMs. In addition, starting in performance year 2019, clinicians could qualify for incentive payments based, in part, on participation in Advanced APMs developed by non-Medicare payers, such as private insurers or state Medicaid programs. The proposed rule also establishes the Physician-Focused Payment Technical Advisory Committee to review and assess additional physician-focused payment models suggested by stakeholder.

Physician-Focused Payment Models (PFPMs): CMS proposes three criteria for PFPMs that outline requirements for (1) paying for high-value care, (2) promoting care delivery improvements, and (3) improving the availability of information for decision-making, including though health IT.

In evaluating PFPM applications, CMS will also consider:

• Anticipated size and scope of the proposed PFPM: number of Medicare beneficiaries, number and scope of eligible clinicians, potential geographic locations, period of performance or clinical episodes of care, number and quality of services.

• A description of the burden of disease, illness, or disability for the target patient population.

• An assessment of the financial opportunity for APM Entities, including a business case for how their participation in the model could be more beneficial for them than traditional Medicare FFS.

Qualifying for Incentive Payments by Significantly Participating in Advanced APMs:

To qualify for incentive payments, clinicians would have to receive enough of their payments or see enough of their patients through Advanced APMs. Clinicians will have the option to be assessed as a group to qualify for incentive payments. In 2019 and 2020, the participation requirements for Advanced APMs are only for Medicare payments or patients. Starting in 2021, the participation requirements for Advanced APMs may include non-Medicare payers and patients. CMS estimates that as many as 90,000 clinicians could receive the bonus for substantially participating in Advanced APMs in the first payment year. As shown below, over time, the requirements would increase to require greater commitment to Advanced APM participation.

Table 2:
Requirements for Incentive Payments for Significant Participation in Advanced APMs
(Clinicians must meet payment or patient requirements)

Payment Year	2019	2020	2021	2022	2023	2024 and later
Percentage of Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

Takeaways/Conclusions

The Proposed Rule is further evidence of CMS's desire to accelerate the transition from volume to value through targeted incentives. This is CMS' strongest attempt to get to risk-based, alternative payment models. MACRA incentivizes physicians to move into "Advanced" or "Other Payer" APMs through several different mechanisms, including a guaranteed five percent bonus for six years and a permanent annual 0.75 percent fee schedule bump.

The initial performance benchmark year is set to begin January 1, 2017. As a result, clinicians will be forced to make practice model selection decisions over the next 12 months. Further, APMs and MIPS will increasingly influence care patterns in favor of treatments that improve downstream clinical,

financial, and patient-reported outcomes. Going forward, those in the health care industry should pay close attention to these incentives and to Medicare's evolving payment structures so they can position their organizations for success in the new value-based world.