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Client Alert:
PROPOSED RULES UNDER MACRA:
A STEP TOWARD PAYING PHYSICIANS FOR QUALITY

I. Introduction

The U.S. Department of Health & Human Services, Centers for Medicare and Medicaid Services ("CMS") recently promulgated a proposed rule implementing the Medicare Access and CHIP Reauthorization Act ("MACRA") with respect to how Medicare reimburses clinicians. MACRA sunsets the Sustainable Growth Rate ("SGR") formula in favor of a new payment system intended to incentivize clinicians to provide higher quality care, and also streamlines several existing quality reporting systems into one. Together, these changes make up the Quality Payment Program ("QPP"), which gives clinicians the opportunity to choose incentives through either the Merit-based Incentive Payment System ("MIPS") or Advanced Alternative Payment Models ("APMs"). While the QPP produces yet another multiplier to be applied to the Medicare physician fee schedule, it encourages clinician participation in Advanced APMs, marking a significant departure from traditional fee-for-service payment. CMS is accepting comments on the proposed rule until June 27, 2016.

II. The MIPS Program

MIPS borrows from three existing reporting programs: the Physician Quality Reporting System ("PQRS"), the Value-based Payment Modifier ("VM"), and the Electronic Health Record ("EHR") for Eligible Physicians ("EPs"). Through MIPS, clinicians would report under the following performance categories:

- Quality: Clinicians would select the six reportable measures that best apply to their practice. One of these measures must be either an outcome or high quality measure, while another must be a "crosscutting" measure.

- Advancing Care Information: Clinicians would report "measures of interoperability and information exchange," and would be rewarded for their performance on measures that are most relevant to their practice.

- Clinical Practice Improvement Activities: Clinicians would select the activities most appropriate for their practice (from over 90 proposed).

- Resource Use: Clinicians would not have to report any measures; CMS would calculate these measures based on claims data.

Intermediaries, such as registries, Qualified Clinical Data Registries, health information technology developers, and certified vendors, would be permitted to submit data on behalf of clinicians. Clinicians' composite scores computed from the four performance categories would translate into a positive, negative, or neutral adjustment to their Medicare fee-for-service payments beginning January 1, 2019. The relative weights of the four performance categories in computing the MIPS composite score would change over time, as follows:

Weights by Performance Category Over Time

Performance Category	2019 MIPS Payment Year	2020 MIPS Payment Year	2021 MIPS Payment Year and Beyond
Quality	50%	45%	30%
Resource Use	10%	15%	30%
CPIA	15%	15%	15%
Advancing Care Information	25%	25%	25%

Under the proposed rule, the initial reporting year for MIPS would begin January 1, 2017, and the final reporting period for PQRS, VM, and EHR-EP would end December 31, 2016. All Medicare Part B physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists would report through MIPS.

Clinicians are not subject to payment adjustments under MIPS if they are newly enrolled in Medicare; have $10,000 or less in Medicare charges, and 100 or fewer Medicare patients annually; or are "significantly participating" in an Advanced APM. Physicians who satisfy Advanced APM requirements would receive a 5% Medicare Part B incentive payment rather than a MIPS payment adjustment. Conversely, clinicians who are "significantly participating" in an Advanced APM, but who do not satisfy the requirements for an APM incentive payment, may decide to accept a payment adjustment under MIPS.

Under MACRA, MIPS must be "budget neutral," meaning that median requirements must be set so that negative adjustments offset positive adjustments. Positive and negative payment adjustments will increase over time, but will not exceed more than 4% in the first year. Additional bonus payments are available for the clinicians with the highest composite scores; $500 million has been allocated for additional bonus payments within the first five years of program implementation, and this amount is not subject to budget neutrality.

A. *Quality Category*

The Quality category would replace PQRS and the quality component of VM, and would account for 50% of the MIPS score in 2019, 45% in 2020, and 30% thereafter. Rather than reporting on the nine PQRS measures, clinicians would choose to report on at least six measures (out of over 200 approved measures), thus allowing for greater diversity in specialty practices and reducing clinician reporting burdens. One of these measures would have to be "crosscutting" (so long as the clinician is "patient-facing"), while another would have to be either an outcome or high-priority measure. Alternatively, clinicians may opt to report a "specialty measures set" tailored to specific conditions and specialties. Measures for the Quality category under MIPS are summarized below:

Cross Cutting Measures: Examples	
Communication and Care Coordination	*Care Plan:* Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.
Community/Population Health	*Preventive Care and Screening; Tobacco Use; Screening and Cessation Intervention:* Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.
Outcome Measures: Examples	
Patient Safety	*Proportion of Patients Sustaining a Bladder Injury at the Time of any Pelvic Organ Prolapse Repair*: Percentage of patients undergoing any surgery to repair pelvic organ prolapse who sustains an injury to the bladder recognized either during or within 1 month after surgery.
Effective Clinical Care	*Proportion with more than one emergency room visit in the last 30 days of life*: Percentage of patients who died from cancer with more than one emergency room visit in the last days of life.
High Priority Measures: Examples	
Effect Clinical Care	*Diabetes; Hemoglobin Ale (HbAlc) Poor Control (>9%)*: Percentage of patients 18-75 years of age with diabetes who had hemoglobin Ale> 9.0% during the measurement period.
Person and Caregiver-Centered Experience and Outcomes	*Osteoarthritis (OA); Function and Pain Assessment:* Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis with assessment for function and pain.

B. *Advancing Care Information Category*

The Advancing Care Information ("ACI") category would replace the Medicare EHR incentive program for physicians, and would account for 25% of the MIPS score. In contrast to the current "meaningful use" program, ACI would not mandate an "all-or-nothing" EHR measurement reporting system, but would instead require clinicians to adopt a customizable set of measures that illustrate how they use certified EHR technology consistently in their medical practices. The ACI would also include MIPS eligible clinicians who were not previously eligible for the original EHR incentive program, and therefore many of the clinicians participating in MIPS may have little to no experience with certified EHR technology. The overall score in this category would be a composite of a base score and a performance score, as described below.

i. The Base Score (Participation Score)

The Base Score would provide up to 50 points toward the ACI score. To receive any ACI score, clinicians must meet each of the six objectives described below.

OBJECTIVES		MEASURES
1	**Protect Patient Health Information**	Security Risk Analysis
2	**Electronic Prescribing**	ePrescribing
3	**Patient Electronic Access**	Patient Access Patient-Specific Education
4	**Coordination of Care Through Patient Engagement**	View, Download or Transmit (VDT) Secure Messaging Patient-Generated Health Data
5	**Health Information Exchange**	Patient Care Record Exchange Request/Accept Patient Care Record Clinical Information Reconciliation
6	**Public Health and Clinical Data Registry Reporting**	Immunization Registry Reporting Syndromic Surveillance Reporting (Optional) Electronic Case Reporting (Optional) Public Health Registry Reporting (Optional) Clinical Data Registry Reporting (Optional)

ii. The Performance Score

Clinicians may earn up to 80 points within the Performance Score category by selecting the measures that best accommodate the needs of their practices from the following objectives:

OBJECTIVES	MEASURES
Patient Electronic Access	Patient Access Patient-Specific Education
Coordination of Care Through Patient Engagement	VDT Secure Messaging Patient-Generated Health Data
Health Information Exchange	Patient Care Record Exchange Request/Accept Patient Care Record Clinical Information Reconciliation

iii. The Public Health Registry Bonus Point

Immunization registry reporting is required as a part of the Base Score. However, clinicians may also report on more than one public health registry beyond the immunization category, and if so, they would receive one additional point for reporting.

vi. The ACI Composite Score

The clinician's base score, performance score, and bonus point would be totaled, with the potential for a total of 131 points, and so long as clinicians earn at least 100 points, they would receive the full 25 point potential in the ACI performance category. Should clinicians earn less than 100 points in total, their performance score would decrease accordingly. CMS has indicated that it would reweight the ACI category to zero in order to accommodate those clinicians for whom the "objectives and measures" are irrelevant, and would duly adjust the relative weights of the other performance categories.

C. *Clinical Practice Improvement Activities Category*

The Clinical Practice Improvement Activities ("CPIA") category would constitute 15% of the MIPS composite score. This category would measure clinician efforts to improve their clinical practice, and would reward initiatives taken to coordinate care, engage beneficiary, and maximize patient safety. A comprehensive list of more than 90 qualifying clinical practice improvement activities would available to clinicians, selected from the following categories:

CPIA SUBCATEGORIES	EXAMPLES
Expanded Practice Access	Same day appointments for urgent needs and after-hours access to clinician advice
Beneficiary Engagement	The establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision-making mechanisms
Achieving Health Equity	The achievement of high quality in traditional areas is rewarded at a more favorable rate for MIPS eligible clinicians that achieve high quality for underserved populations, etc.
Population Management	Monitoring health conditions of individuals to provide timely health care interventions or participation in QCDR
Patient Safety and Practice Assessment	Through the use of clinical or surgical checklists and practice assessments related to maintaining certification
Emergency Preparedness and Response	Measuring MIPS eligible clinician or group participation in the Medical Reserve Corps, etc.
Care Coordination	Timely communication of test result, timely exchange of clinical information to patients and other MIPS eligible clinicians or groups, and use of remote monitoring or telehealth
Participating in an APM	Including a medical home model
Integration of Primary Care and Behavioral Health	Evaluating co-location of behavioral health and primary care services or shared behavioral health and primary care records.

Clinicians' CPIA scores would be composites of the weighted scores of their clinical practice improvement activities; highly weighted activities would be worth 20 points, while medium-weighted activities would be worth only 10 points, with the potential of 60 points in total. For clinicians who are not "patient-facing," such as radiologists and pathologists, only one activity will need to be reported. According to CMS, "MIPS eligible clinicians or groups that are certified as a patient-centered medical home or comparable specialty practice must be given the highest potential score for the CPIA category, while MIPS eligible clinicians or groups who are participating in an APM must earn at least one half of the highest potential score for this performance category."

D. *The Resource Use Category*

The Resource Use, or Cost, category would contribute 10% to the MIPS composite score in 2019, 15% in 2020, and 30% in subsequent years. The score in this category (which replaces the cost component of the VM) is based on Medicare claims, thus requiring no reporting from clinicians. According to CMS, "clinicians that deliver more efficient, high quality care achieve better performance, so clinicians scoring the highest points would have the most efficient resource use." Each measure under this category would be worth up to 10 points, and in order for a cost measure to be scored, clinicians must see a minimum of 20 patients. The scoring under this category would be based on more than 40 episode-specific measures, and the score of all of the measures applicable to a particular clinician would be averaged. As with ACI, CMS would

reweight the Resource Use category to zero for clinicians who do not meet the patient volume criteria necessary to receive scored cost measures, and reweight the other MIPS performance category scores to compensate.

IV. Advanced Alternative Payment Models

For clinicians who wish to further transform how they provide and bill for health care services, CMS's proposed rule provides an alternate route, through participation in an Advanced APM. Advanced APMs are those APMs in which clinicians accept financial risk for providing coordinated, high-quality care.

A. *Standards for Advanced APMs*

Under the proposed rule, APMs that can qualify as Advanced APM include the Comprehensive End Stage Renal Disease Care Model; the Comprehensive Primary Care Plus model; the Medicare Shared Savings Program (Tracks 2 & 3 only); the Next Generation ACO Model; and the Oncology Care Model Two-Sided Risk Arrangement. To qualify as an Advanced APM, an APM must (i) require its participants to use certified EHR technology; (ii) pay providers for covered professional services based on quality measures comparable to those used in the MIPS Quality category; and (iii) either require participating providers to bear financial risk for monetary losses that exceed a nominal amount, or be a Medical Home Model (as defined under the rule).

Clinicians who participate to a sufficient extent in (and receive a substantial portion of their revenue through) an Advanced APM would meet the Qualifying APM Participant ("QP") standards and thus qualify for incentive payments, which will begin at 5% in 2019 and may increase thereafter. Standards for sufficient participation in Advanced APMs are outlined below:

Requirements for Incentive Payments for Significant Participation in Advanced APMs

Payment Year	2019	2020	2021	2022	2023	2024 and after
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%

B. *Intermediate Options*

Recognizing that many clinicians may participate to some extent in APMs, but may not qualify under the "sufficient participation" standard as required by the proposed rule, CMS has also created financial incentives within MIPS. For example:

- MIPS clinicians participating in APMs would receive points in the Clinical Practice Improvement Activities category;

- Wherever feasible, the CMS rule coordinates standards between the MIPS and the APM programs in order to facilitate straightforward movement between the two; and

- Those Advanced APM participants who do not qualify for the incentive payments discussed above would be able to decide whether to opt for MIPS reimbursement adjustments, but in order to opt out of the adjustments for 2019 and 2020, the clinician must either receive 20% of their Medicare payments or accept 10% of their Medicare patients through an Advanced APM.

All clinicians will report through the MIPS reporting system throughout the first year, which will help clinicians determine whether they meet the criteria for the Advanced APM track.

V. Potential Challenges to Physicians

The implementation of the MIPS program presents several challenges. Physicians may experience a delay of two years or more between performance reporting and payment adjustments. Additionally, because MIPS indices will be reported and measured at the individual physician level, but distributed at the Taxpayer Identification Number ("TIN") level, practice groups could be affected by the performance of former group members. Finally, many participants may find it very challenging to anticipate their performance scores and reimbursement rates due to the complex performance score calculation process and the possibility that even within a specific TIN, physicians could be reporting across specialties, and therefore might be evaluated based on dissimilar measures and awarded disparate performance scores.

VI. Conclusion

The proposed rule attempts to shift the American healthcare system away from volume-centered, fee-for-service reimbursement, and toward value-based payment. CMS clearly took significant time and care in creating the quality measures and the methods through which they will be calculated. The process will be complex and cumbersome, however, and will likely require significant administrative oversight and investments in technical infrastructure. Accordingly, provider organizations with greater resources will be at an advantage.

Healthcare providers are encouraged to send comments to CMS regarding the proposed rule. The proposed rule and a comment submission link are available online at: https://www.federalregister.gov/articles/2016/05/09/2016-10032/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm.