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CMS PROPOSED RULE: QUALITY PAYMENT PROGRAM
Merit-based Incentive Payment Systems (MIPS) and Advanced Alternative Payment Models (APMs)

The Centers for Medicare and Medicaid Services (CMS) recently issued a Proposed Rule containing a new Quality Payment Program which was created from the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 to replace the Sustainable Growth Rate reimbursement formula. Currently, Medicare measures value and quality of care through multiple independent programs – the Physician Quality Reporting Systems (PQRS), Value Modifier (VM) program, and the Electronic Health Record (EHR) Incentive program. The proposed rule streamlines these programs and an added component for Clinical Practice Improvement Activities into one platform, the new Merit-based Incentive Payment System (MIPS).

This program furthers CMS' efforts to move away from fee-for-service billing and more toward performance-based and bundled payment models. It applies to providers only; hospitals and facilities are not included.

In addition to MIPS, the Quality Payment Program contains a second route that providers may qualify to participate in: Advanced Alternative Payment Models (APMs). CMS defines the APMs as the "…Innovation Center models, Shared Savings Program tracks, or statutorily-required demonstrations where clinicians accept both risk and reward for providing coordinated, high-quality, and efficient care." These models are also required to meet criteria for quality-based and for using Electronic Health Records (EHRs). Participating, to a sufficient extent, would exempt physicians from MIPS payment adjustments and qualify them for a five percent Part B incentive payment.

As CMS anticipates that the APMs would apply to a comparatively small segment of clinicians in the beginning, <u>all physicians will report through MIPS the first year</u>. As such, this paper will focus on MIPS. Information about the APMs will be addressed in future correspondence.

It is important to note that full details of this initiative are not yet available. CMS is expected to issue a draft of the MIPS guidelines later this summer, with the final rules expected out in the fall of 2016. The MACRA final rule is expected to be published by November 1, 2016. In the meantime, APS will attempt to provide a general overview of the MIPS information available at this point.

Who is expected to participate?

Medicare Part B physicians are expected to be subject to MIPS unless *exempted* due to:

- Being in first year of enrollment with Medicare Part B; OR
- Having ≤ $10,000 in Medicare charges and ≤ 100 Medicare patients; OR
- Certain, significant participation in Advanced Alternative Payment Models (Advanced APMs)

According to CMS, clinicians will have the option to be assessed as a group across all four performance categories.

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How Does MIPS "Work?"

MIPS allows clinicians to be paid for successfully providing high quality, efficient care in four performance categories (listed below) by earning points across all categories. Scoring will measure overall delivery of care; therefore, reporting will not be limited to the care provided to Medicare beneficiaries.

1. **Resource Use**
   - Accounts for 10% of total score in year 1
   - Replaces the Cost component of the Value Modifier Program
   - Score is based on Medicare claims; there are no additional reporting requirements for physicians
   - There are expected to be 40 episode-specific measures to choose from designed to reflect the differences between specialties

2. **Quality**
   - Accounts for 50% of total score in year 1
   - Replaces the PQRS and quality component of the Value Modifier Program
   - 6 measures would be reported versus 9 currently required by PQRS
   - One of these measures must be a cross-cutting measure, and one must be an outcome high-value measure.
     - High value measures are related to patient outcomes, appropriate use, patient safety, efficiency, patient experience, or care coordination.
   - Instead of reporting 6 measures, providers may choose to report a specialty measure set that is designed around certain conditions and specialty types
   - There are expected to be 200 measures to choose from with more than 80% tailored for specialists

3. **Clinical Practice Improvement Activities**
   - Accounts for 15% of total score in year 1
   - Focuses on care coordination, beneficiary engagement and patient safety
   - Pathologists or radiologists will only need to report on one activity
   - It is anticipated that 90 weighted options in multiple categories will be available so physicians can choose the activities that best fit their practice

4. **Advancing Care Information**
   - Accounts for 25% of total score in year 1
   - Replaces the EHR Incentive Program ("Meaningful Use")
   - Customizable measures reflect how EHR technology is used in the day-to-day practice
   - Multiple key measures for reporting interoperability and information exchange

When is MIPS Expected to go into Effect?

The first performance year for MIPS is slated for January 1, 2017 through December 31, 2017.

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How Will the Payment Adjustments be Applied?

Payment adjustments will always follow the performance/reporting period by 2 calendar years. Therefore, payment adjustments for the 2017 performance/reporting year will be applied in 2019.

The law requires MIPS to be budget neutral; individual MIPS scores would be used to compute a positive, negative, or neutral adjustment to providers' Medicare Part B payments.

For the first year, depending on the variations among MIPS scores, adjustments will be calculated to cap negative adjustments at 4 percent, with positive adjustments of up to 4 percent. The positive adjustments will be scaled up or down to achieve budget neutrality, which could make the maximum positive adjustment lower or higher than 4 percent.

Payment adjustment percentages will be based on the relationship between a clinician's Composite Performance Score (CPS) across the four performance categories and the MIPS performance threshold. A CPS below the performance threshold will result in a negative payment adjustment while a CPS above that threshold will yield a neutral or positive payment adjustment. A CPS ≤ 25% of the threshold will yield the maximum negative adjustment of -4%. Both positive and negative adjustments would increase over time. The projected maximum negative adjustments for each year are:

2019	2020	2021	2022 and after
4%	5%	7%	9%

As certain medical specialties are inherently non-patient-facing, their opportunity to participate was felt to be limited in the development period of this program. According to The College of American Pathologists (CAP), it responded to Medicare's request for input, providing feedback that gave CMS the ability to create measures and activities for providers who don't have face-to-face patient interaction so they can more readily participate in, and comply with, quality requirements impacting payment under this initiative.

APS will continue to follow progress on this proposed rule and will provide details as they become available. At that time, we will be able to work with our clients individually to determine participation eligibility and applicable measures/activities in the four performance categories as well as implementing any new processes required for reporting under the MIPS program.