

MEMORANDUM

To: Clients

From: Powers Pyles Sutter & Verville

Date: Final Rules Implementing MACRA Merit-Based Incentive Payment System and Advanced Alternative Payment Models

Subject: October 20, 2016

On October 14, 2016 the Centers for Medicare and Medicaid Services (CMS) released its [final rule](#) with comment period (final rule) implementing provisions of the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA). Set forth below is an overview of the most significant elements of the final rule. CMS has also made available facts sheets and other educational materials on the final rule at <https://qpp.cms.gov/education>. The agency has also established a new website on the Quality Payment Program at <https://qpp.cms.gov>.

Background

MACRA, enacted in 2015, repealed the flawed Medicare sustainable growth rate (SGR) for updating Medicare payments to physicians and replaced it with the Quality Payment Program (QPP) which is intended to create incentives for the provision of high-quality and cost effective care. The two principal components of the QPP are the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (AAPMs). MIPS replaces the current Physician Quality Reporting System (PQRS), the Physician Value-Based Payment Modifier (VM) and the incentives for meaningful use of Electronic Health Records (EHRs) beginning with performance year 2017 with payment adjustments beginning in 2019.

The final rule makes significant changes to the proposed rule released earlier this year based in large part on comments received from stakeholders. Specifically, it (1) provides for a 2017 transition year for MIPS reporting that allows clinicians to avoid MIPS penalties with reduced MIPS reporting obligations; (2) raises the low-volume MIPS exception threshold to \$30,000 in annual Medicare Part B allowed charges **or** more than 100 Medicare patients a year; and (3) simplifies the “all-or-nothing” requirements for use of certified EHR. The agency has also signaled that it will take a more flexible approach to the financial risk required of AAPMs and will also modify certain existing programs to qualify as AAPMs in 2018.

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MIPS

- **Budget Neutrality:** MIPS incentives and penalties are required by law to be budget neutral with the exception of \$500 million available outside of budget neutrality rules for “exceptional performers.” This means that positive adjustments are funded by penalties for under performers which inevitably makes this a system of winners and losers. CMS estimates that it will distribute approximately \$199 million in incentive payments in 2019 and an estimated \$249 million in 2020, plus the exceptional performer bonuses.
- **Overall Impact of MIPS:** CMS estimates that about initially 60% or 1.3 million clinicians will be eligible for participation in MIPS and that approximately 40% will be excluded either because they are newly enrolled, meet the low-volume threshold, or are qualified participants in an AAPM. The agency also estimates that of those not excluded from MIPS, between 91.9% and 94.7% are expected to receive positive or neutral payment adjustments.
- **Low-Volume Exception:** The final rule increases the threshold for the low-volume exception to **\$30,000** in Medicare allowed charges **or** 100 or fewer Medicare patients. Clinicians with annual Part B allowed charges of \$30,000 or less **or** who see 100 or fewer Medicare patients in a year will be exempted from MIPS. This is a significant change from the proposed rule which set the threshold at \$10,000 **and** 100 or fewer Medicare patients and is in response to concerns expressed by many in the medical community that the proposed rule would have a disproportionately negative impact on small practices. As a result of this change, CMS estimates that 32.5% of eligible clinicians and 45% of those in solo practice or in groups of fewer than 10 will be excluded based on the low-volume exception. However, CMS also has signaled that these thresholds will likely change over time and fewer clinicians will be excluded in the future.

In addition, CMS will apply the exception at the group level for clinicians billing as a group. Therefore, those seeking to qualify for this exception may need to bill individually. CMS has also indicated that it will inform physicians in advance, based on prior year’s billings, whether they will qualify for the exception but will also use current year’s data to qualify someone who did not qualify based on historical data. However, CMS states that it will not use current data to disqualify someone previously qualified.

- **MIPS Transitional Year – Special Rules:** In September of this year CMS announced that it would ease MIPS implementation in 2017 by providing clinicians with more options for MIPS reporting. The final rule provides the details on this. CMS describes three options under MIPS for avoiding a negative Medicare adjustment for 2019 based on 2017 performance as set forth in the Table below:

Options for MIPS Reporting During 2017

Options for MIPS Participation	Time Period	Quality Reporting	Clinical Improvement Activities	Advancing Care Information	Resource Use/Cost	Payment Impact
Full Participation	At least 90 days	6 measures including 1 outcomes measure or specialty specific measure set	4 medium weighted or 2 high-weighted for full credit but for small practices (9 or fewer clinicians) 1 high-weighted or two medium-weighted;	Report on 4 base score measures for 50% credit in 2017;(5 required measures in 2018); report on optional measures for higher score;	No reporting required; zero weight in 2017	Eligible for positive MIPS adjustment and additional adjustment for “exceptional performance”
Partial Participation	Continuous 90-day period	More than one quality measure or	More than one improvement activity, or	more than 4 base score measures	No reporting required; zero weight in 2017	Avoid negative payment adjustment; possibly qualify for positive adjustment
Minimal Participation	Any time during performance year	One quality measure for one patient or	One improvement activity or	4 base score measures	No reporting required; zero weight in 2017	Avoid negative payment adjustment
No Participation						Negative 4% adjustment

- MIPS Reporting Dates:** While clinicians may start to collect performance data on January 1, 2017, they also may choose to start collecting anytime between January 1 and October 2, 2017. Regardless of when a clinician chooses to start collecting data, performance data must be submitted by March 31, 2018. The first payment adjustments based on performance go into effect on January 1, 2019.

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- **MIPS Scoring:** MIPS scoring is based on performance in four categories: (1) quality (replaces PQRS); (2) clinical practice improvement activities; (3) advancing care information (i.e. use of EHR) (replaces meaningful use incentive program); and (4) cost or resource use (replaces value-based modifier). In response to concerns from many in the physician community, CMS will not include cost in the MIPS scoring calculation during 2017 but will begin counting it in 2018. Thus, in 2017, quality will count for 60% of a clinician's MIPS composite score, with improvement activities counting for 15% and advancing care information 25%. For 2017, CMS has set a performance threshold of 3 points which will allow those who successfully report one quality measure for one patient to avoid a downward adjustment. Those that submit additional data may qualify for varying levels of positive adjustments which, however, will be scaled based on budget neutrality. Those with a score of 70 or above qualify for "exceptional performance" payments from a fund of \$500 million that is not subject to budget neutrality.
- **Quality Data Completeness Criteria:** CMS will not implement the more stringent data completeness standards set forth in the proposed rule. The agency had proposed that quality reporting include 90% of patients (both Medicare and non-Medicare) when reporting by registries or via EHR and 80% of Medicare patients for those reporting via claims. Instead, for those reporting by registry or EHR, successful MIPS quality reporting will require reporting on 50% of patients in 2017 and 60% in 2018. Those reporting via claims must report on at least 50% of Medicare Part B patients for 2017 and 60% for 2018. However, for the 2017 transition year, clinicians who report on less than 50% of patients can still receive 3 points for reporting the measure and thus avoid a negative adjustment.
- **Clinical Practice Improvement Activities:** CMS has reduced the reporting burden from three high-weighted activities or six medium-weighted activities to two high-weighted activities or four medium-weighted activities to achieve full credit in this category. Small, rural or HPSA physicians can receive full credit by reporting only two improvement activities regardless of weight. Improvement activities must be reported for a 90-day performance period.
- **Advancing Care Information:** CMS has reduced the reporting burden from 11 measures in the Base Score to 4 in 2017 and 5 thereafter. It has also shortened the reporting period from one year to 90 days for 2017 and 2018. It also finalized its proposal to eliminate the Clinical Decision Support and Computerized Physician Order Entry measures. However, clinicians must still report on all measures in the base score to earn any points in this category.
- **Cost:** Cost will have zero weight in the composite performance score in 2017 and 10% in 2018. In 2019 and beyond it will make up 30% of the composite score. CMS has retained the controversial total per capita cost and Medicare Spending Per Beneficiary

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administrative claims cost measures. Patient condition groups and patient relationship codes, currently under development, are designed to improve the method for attributing beneficiaries to clinicians, beginning in 2018.

- **Special Help for Small Practices:** The MACRA legislation requires CMS to help small practices achieve compliance by allocating \$100 million in technical assistance for MIPS eligible clinicians in small practices, rural areas, and in health professional shortage areas including Indian Health Service, tribal, and urban Indian clinics. The assistance will be available to those in practices of 15 or fewer clinicians with priority given to rural and underserved areas.

MACRA also authorizes CMS to establish “virtual groups;” however CMS has chosen not to implement virtual groups in 2017 but will implement them in the future.

AAPMs

- **Participation Levels:** Clinicians that meet the thresholds for participation in AAPMs will receive a 5% bonus payment through 2024 and do not have to report under MIPS. For the first year, a clinician must receive 25% of Medicare payments or provide care to 20% of Medicare patients through an AAPM. In 2019 these amounts increase to 50% and 35% respectively and in 2021 and after, to 75% and 50%, respectively.
- **Future Payment Updates:** Beginning in 2026, the update factor for those with substantial participation in AAPMs will be 0.75% while that for those who do not achieve substantial participation will be 0.25%.
- **All Payer AAPMs:** Beginning in 2021, CMS will recognize an All-Payer Combination Option in which clinicians can receive Medicare incentives based on participation in Medicare AAPMs and AAPMs with other payers.
- **Required Risk:** CMS has also reduced the amount of risk that AAPMs will have to incur to qualify and has simplified the definition of “more than nominal risk” required of AAPMs by eliminating the requirements for marginal risk and minimum loss. AAPMs must now only meet the requirement for total risk.

CMS expects that the following APMs will qualify as AAPMs in 2017:

- Shared Savings Program (i.e. ACOs) Tracks 2 and 3
- Next Generation ACO Model
- Comprehensive ESRD Care Model (Large Dialysis Organization (LDO) arrangement

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- Comprehensive ESRD Care Model (Non- LDO two-sided risk arrangement)
- Comprehensive Primary Care Plus

CMS has also changed the definition of AAPMs to enable additional organizations to qualify. A list of organizations that will qualify for the 2017 performance period will be published by January 1, 2017. CMS has signaled that it will expand the list to include Track One+ ACOs (those that accept increased down-side risk), the Oncology Care Model, a new voluntary bundled payment model, and cardiac and joint care models for the 2018 performance period. .

- **AAPM Participation Estimates:** Based on the changes made to the AAPM criteria and other factors, CMS has increased its estimate of the clinicians that will qualify for the AAPM incentives from 30,000 to 90,000 (proposed rule) to 125,000 to 250,000 clinicians by performance year 2018. They are estimated to receive between \$333 million and \$571 million in APM incentive payments in 2019. This compares with 592,000 to 642,000 clinicians estimated to participate in MIPS in 2017 and \$199 million in MIPS budget-neutral adjustments plus \$500 million for exceptional performers.

Physician-Focused Payment Model Technical Advisory Committee (PTAC)

The PTAC, established by MACRA, is an 11-member independent federal advisory committee that will review and make recommendations on physician-focused payment models. The PTAC is intended to create an avenue for creation of new and innovative physician-driven payment models that may qualify as AAPMs. Criteria to be used by the PTAC in evaluating physician-focused payment model proposals include (1) value over volume – incentives to deliver high-quality care; (2) flexibility for practitioners; and (3) improving quality at no additional cost or at decreased cost.
