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| Changing the Way You Get Paid: CMS Issues Final Rule Implementing MACRA |  | [CMS-5517-FC] - Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models |
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## Next Steps

## CMS is accepting comments on the final rule at [Regulations.gov](https://www.regulations.gov/document?D=CMS-2016-0060-3944) until December 19, 2016. The Quality Payment Program takes effect January 1, 2017.

## Additional Resources

[MACRA Legislation](https://www.congress.gov/bill/114th-congress/house-bill/2/text)

[Final Rule](https://www.federalregister.gov/documents/2016/11/04/2016-25240/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm)

[CMS Executive Summary of Final Rule](https://qpp.cms.gov/docs/QPP_Executive_Summary_of_Final_Rule.pdf)

[CMS Slide Presentation](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-Long-Version-Executive-Deck.pdf)

[CMS Quality Payment Program Website](https://qpp.cms.gov)

[Explore Quality Payment Program Measures](https://qpp.cms.gov/measures/performance)

[AMA Resources](https://www.ama-assn.org/practice-management/understanding-medicare-payment-reform-macra)

[AMA Payment Model Evaluation Tool](https://apps.ama-assn.org/pme/#/)

[ISASS Resources](https://www.isass.org/public-policy/macra-changing-the-way-you-get-paid/)

[Center for Healthcare Quality and Payment Reform](http://www.chqpr.org/index.html)

[A Guide to Physician-Focused Alternative Payment Models](http://www.chqpr.org/downloads/Physician-FocusedAlternativePaymentModels.pdf)

# Overview

On October 14, 2016, the Centers for Medicare and Medicaid Services (CMS) released a final rule to begin implementing the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA). MACRA was bipartisan legislation signed into law in the spring of 2015 to permanently repeal the Sustainable Growth Rate (SGR), streamline quality reporting programs, and provide incentive payments for participation in advanced alternative payment models. The final rule establishes the framework for the umbrella Quality Payment Program (QPP) and includes details on the two new tracks for Medicare payment: Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs).

Goals: Value-Based Payments and Alternative Payment Models in Medicare

* 30 percent of Medicare payments tied to quality or value through alternative payment models by the end of 2016 and 50 percent by the end of 2018 (Note: The 2016 goal has already been achieved.)
* 85 percent of Medicare fee-for-service payment tied to quality or value by the end of 2016 and 90 percent by the end of 2018

Current System

* Fee-for-service model - paying for the quantity of services performed
* The Sustainable Growth Rate (SGR) was established in 1997 to control the cost of Medicare payments to physicians. Under the SGR, if overall physician costs exceed target Medicare expenditures, physician payments are cut across the board. Each year, Congress passed temporary “doc fixes” to postpone the SGR cuts each year.
* Fragmented and burdensome data reporting requirements

What does MACRA do?

* Repeals the SGR
* Streamlines quality reporting programs – Payment adjustments under the current Medicare EHR Meaningful Use Incentive Program, the Physician Quality Reporting System (PQRS), and the Value Modifier (VM) Program will sunset. Certain components of these three programs will be carried forward into MIPS.
* Requires physicians to choose between two newly designed payment paths
* Provides incentive payments for participation in advanced alternative payment models
* Gives physicians a fee increase of 0.5 percent per year in years 2016 through 2019 (From 2020 to 2025, no across-the-board fee increase will be granted as physicians will be participating in one of the two new paths)

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| Merit-Based Incentive Payment System (MIPS)Participation in MIPS constitutes one of two payment paths under the Quality Payment Program. MIPS retains the traditional fee-for-service payment model and streamlines the current physician reporting programs: Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Meaningful Use Incentive Program. These programs will sunset at end of 2018 and MIPS will begin adjusting payments in 2019. Who participates in MIPS? “MIPS eligible clinicians” include physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists who bill under Medicare Part B in excess of $30,000 per year **AND** provide care for more than 100 Medicare patients a year. Who is excluded from MIPS?* Clinicians newly enrolled in Medicare Part B (these clinicians are excluded for the first year)
* Clinicians that meet or exceed the low volume threshold (Medicare Part B billing is less than or equal to $30,000 **OR** the clinician provides care to 100 or fewer Medicare patients in one year)
* Certain clinicians participating in Advanced APMs (must receive 25 percent of Medicare payments OR see 20 percent of Medicare patients through an Advanced APM)
* Hospitals and facilities (MIPS applies only to clinicians)

MIPS Performance Categories* MIPS has four weighted performance categories:

**Merit-Based Incentive Payment System (MIPS)****Advanced Alternative Payment Models (Advanced APMs)**Select one of two payment tracks:**Quality Payment Program**How is MACRA being implemented?CMS is implementing MACRA through rulemaking. The final rule issued on October 14, 2016 establishes an umbrella Quality Payment Program with two new pathways for payment: 1. Merit-Based Incentive Payment System (MIPS) and 2. Advanced Alternative Payment Models (Advanced APMs). If a physician makes no choice or is deemed ineligible to participate in an alternative payment model, he/she will be assigned to MIPS.  |  |  |

1. Quality (60 percent of overall score in the transition year) – Replaces Physician Quality Reporting System (PQRS) and some components of the Value Modifier (VM)
* Clinicians must report six of 300 available measures (one must be an outcome measure or high-priority measure (i.e. outcome measure, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination))
* If fewer than six measures apply to the individual MIPS eligible clinician or group, then the MIPS eligible clinician or group will only be required to report on each measure that is applicable.
1. Cost (zero percent of overall score in the transition year) – Replaces the cost component of the VM
* There are no reporting requirements for clinicians as CMS calculates this category based on claims.
* As performance feedback is available on at least an annual basis, the cost performance category contribution to the final score will gradually increase from 0 percent in 2017 to 10 percent in 2018 to 30 percent in 2019 and beyond.
1. Improvement Activities (15 percent of overall score in the transition year) – “New” domain added to the previously existing other three
* Clinicians attest to participation in activities that improve clinical practice
* Clinicians must attest to two 20-point high weighted activities, four 10-point medium-weighted activities, or another combination of high and medium weighted activities equaling 40 points or more to achieve full credit in the Improvement Activity category out of 90+ activities (i.e. expanded practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, participation in an APM, achieving health equity, integrating behavioral and mental health, emergency preparedness and response)
* A lower reporting threshold of two medium-weighted or one high-weighted improvement activities are required for small, rural, health professional shortage areas and non-patient facing clinicians to receive full credit.
1. Advancing Care Information (25 percent of overall score in the transition year) - Formerly electronic health record (EHR) Meaningful Use (MU) Program
* Measures and objectives focus on the secure exchange of health information and the use of certified electronic health record technology (CEHRT) to support patient engagement and improved healthcare quality.
* Clinicians must report on all five required measures in the Base Score with up to an additional nine optional measures in the Performance Score, for which clinicians may receive additional percentage points. The Base Score measures are met via one unique patient or attestation to a “yes” option. The Performance Score measures are eligible for partial credit.
* For the transition year, CMS will award a bonus score for improvement activities that utilize CEHRT and for reporting to public health or clinical data registries.

Use this [tool](https://qpp.cms.gov/measures/performance) to browse, review, and identify MIPS measures and activities applicable to your practice across the four performance categories.

MIPS Final Score

* The four performance categories are used to calculate a final MIPS score (0-100 points)
	+ Scoring method accounts for:
		- weights of each performance category
		- exceptional performance factors
		- availability and applicability of measures for different categories of clinicians
		- group performance
		- special circumstances including small practices, rural practices, etc.
	+ To calculate the final score, CMS uses the following formula: (Quality performance category score x Quality performance category weight) + (Cost performance category score x Cost performance category weight) + Improvement Activities category score x Improvement Activities category weight) + Advancing Care Information performance category score x Advancing Care Information category weight) x 100
	+ Transition Year Final Score greater than or equal to 70 points = positive payment adjustment and eligible for exceptional performance bonus (minimum of additional 0.5 percent)
	+ Transition Year Final Score from 4-69 points = positive payment adjustment but not eligible for exceptional performance bonus
	+ Transition Year Final Score of 3 points = neutral payment adjustment
	+ Transition Year Final Score of 0 points = negative payment adjustment of -4 percent (0 points means the clinician did not participate in MIPS)

How to participate in MIPS?

* Clinician can participate as an individual (use individual unique Tax Identification Number (TIN) and National Provider Identifier (NPI))
* Clinician can participate as part of a group (use a single TIN with two or more NPIs that have assigned billing to the TIN or as an APM entity)
* “Virtual groups” will not be implemented in year one of MIPS

How to submit data to CMS for MIPS?

* Data submission depends on whether the clinician is reporting as an individual or as a group
* Data can be submitted via claims, QCDR, Qualified Registry, EHR Vendors, CMS Web Interface, and CAHPS

MIPS Performance Cycle

* Performance evaluated on an annual basis from January 1-December 31
* Performance in 2017
* Data collection in 2018
* Payment adjustments in 2019

MIPS Payment Adjustments

* Payment adjustment of up to +/- 4 percent in 2019
* Payment adjustment of up to +/- 5 percent in 2020
* Payment adjustment of up to +/- 7 percent in 2021
* Payment adjustment of up to +/- 9 percent in 2022 and beyond

Public Reporting of MIPS Data

Data reported under MIPS will be publicly reported on the CMS Physician Compare website.

# Alternative Payment Models (APMs)

Only participants in **Advanced** APMs at MACRA thresholds qualify for 5 percent lump sum payments. The rule finalizes two types of Advanced APMS: Advanced APMs and Other Payer Advanced APMs.

**Advanced APMs** must meet the following criteria:

1. Participation in use of certified EHR technology

* At least 50 percent of eligible clinicians in the APM entity must use certified EHR technology to document and communicate clinical care

2. Payment based on quality measures comparable to those in the Quality performance category under MIPS

* At least one of these measures must be an outcome measure if an appropriate outcome measure is available on the MIPS measure list.
* “Comparable” means any actual MIPS measures or other measures that are evidence-based, reliable, and valid.

3. Either requires APM entities to be a Medical Home Model expanded under CMMI authority OR bear more than nominal financial risk for monetary losses

* Financial Risk – Bearing financial risk means that the Advanced APM may do one or more of the following if actual expenditures exceed expected expenditures:
	+ Withhold payment for services to the APM Entity and/or the APM Entity’s eligible clinicians
	+ Reduce payment rates to the APM Entity and/or the APM Entity’s eligible clinicians
	+ Require direct payments by the APM Entity to CMS
* Total Amount of Risk – An APM will qualify as an Advanced APM in 2019 and 2020 if the APM Entity is either:
	+ at risk of losing 8 percent of its own revenues when Medicare expenditures are higher than expected, or
	+ at risk of repaying CMS up to 3 percent of total Medicare expenditures, whichever is lower.
	+ CMS states that it plans to increase the risk standard to 10 or 15 percent of revenues in future years.

**Other Payer Advanced APMs** must meet the following criteria:

1. Participation in use of certified EHR technology

2. Payment based on quality measures comparable to those in the Quality performance category under MIPS

3. Either requires APM entities to be a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under CMMI authority OR bear more than nominal financial risk for monetary losses if actual aggregate expenditures exceed expected aggregate expenditures

Which Current APMs will be considered Advanced APMs in 2017?

* Shared Savings Program (Tracks 2 and 3)
* Next Generation ACO Model
* Comprehensive End Stage Renal Disease Care Model (Two-Sided Risk Arrangements)
* Comprehensive Primary Care Plus (CPC+)
* Oncology Care Model (Two-Sided Risk Arrangement)

How do I become a Qualifying Advanced APM participant?

* In order to qualify, clinicians must have a certain percentage of patients (20 percent in 2017) or payments (25 percent in 2017) through an Advanced APM
* Qualifying APM participants will be excluded from MIPS AND receive a 5 percent lump sum bonus in 2019-2024 and higher fee schedule updates starting in 2026

MIPS APMs

* MIPS APM participants can improve their MIPS scores in APMs that do not meet criteria to be Advanced APMs or do not meet the revenue or patient thresholds to qualify for bonuses.
* MIPS APMs are not Advanced APMs and as such, participants in MIPS APMs will be subject to MIPS reporting requirements and the MIPS payment adjustment and will not
* MIPS eligible clinicians who participate in MIPS APMs will be scored using the APM scoring standard instead of the generally applicable MIPS scoring standard.
* APM must base payment incentives on performance (either at the APM Entity or eligible clinician level) on cost/utilization and quality
* For 2017, the following models are considered MIPS APMs:
	+ Comprehenisve ESRD Care (CEC) Model (All Arrangements)
	+ Comprehensive Primary Care Plus (CPC+) Model
	+ Shared Savings Program Tracks 1, 2 and 3
	+ Next Generation ACO Model
	+ Oncology Care Model (OCM) (All Arrangements)

# Physician Focused Payment Models

Physician Focused Payment Model proposals from stakeholders, such as specialty societies, will be submitted to the Physician-Focused Payment Models Technical Advisory Committee (PTAC) that was created by MACRA. The PTAC is an 11-member independent federal advisory committee to the Secretary of the Department of Health and Human Services (HHS). The PTAC will review stakeholders’ proposed physician-focused payment models (PFPMs), and make comments and recommendations to the Secretary regarding whether the PFPMs meet criteria established by the Secretary. PTAC’s comments and recommendations will be reviewed by the CMS Innovation Center and the Secretary when developing and approving new PFPMs.

# Next Steps

CMS is accepting comments on the final rule at [Regulations.gov](https://www.regulations.gov/document?D=CMS-2016-0060-3944) until December 19, 2016. The Quality Payment Program takes effect January 1, 2017. CMS anticipates that the learning and development period will last longer than the first year (2017) as the program gets up and running and envisions 2018 to also be transitional in nature to provide a ramp-up of the program and of the performance thresholds. CMS anticipates making proposals on the parameters of this second transition year through rulemaking in 2017.