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CMS Finalizes Sweeping Changes to Medicare Physician Payments

By Miranda A. Franco*

The Centers for Medicare & Medicaid Services has released the highly anticipated Final Rule implementing the Medicare physician payment reforms enacted as part of the Medicare Access and CHIP Reauthorization Act of 2015. The author of this article discusses the final rule and its implications.

The Centers for Medicare & Medicaid Services ("CMS") recently released the highly anticipated Final Rule implementing the Medicare physician payment reforms[1] enacted as part of the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"). At nearly 2,400 pages, the enormity of the rule reflects the transformative intent of the law. It is the most comprehensive reform of Medicare since the creation of the Affordable Care Act in 2010 and it took effect January 1, 2017.

MACRA repealed the Medicare sustainable growth rate ("SGR") formula and directed the Secretary of Health and Human Services to implement reforms to tie physician payment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 quality programs, including the Physician Quality Reporting System ("PQRS"), the Value-Based Payment Modifier and the Electronic Health Records ("EHR") Incentive Program (Meaningful Use). MACRA also mandates incentives for clinicians to participate in alternative payment models ("APMs") that focus on coordinating care, improving quality, and reducing costs.

CMS made several significant changes when promulgating the Final Rule to simplify requirements and provide additional flexibility for clinicians. In the Final Rule, the Department of Health and Human Services ("HHS") introduces a transition year, outlines support for smaller independent practices and expands eligibility requirements for Advanced Alternative Payment Models.

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1 https://qpp.cms.gov/docs/CMS-5517-FC.pdf.

The Final Rule included a 60-day comment.

SUMMARY OF SIGNIFICANT HIGHLIGHTS

- The Final Rule removes the negative payment adjustment under MIPS in 2017 by allowing clinicians to submit one quality measure, or one improvement activity, or the required measures in the advancing care information category to avoid a penalty.
- The Final Rule allows for a flexible, pick-your-own-pace approach in the first year.
- Small clinicians are afforded relief under the raised low-volume threshold. CMS also finalized a plan to set aside $20 million per year for five years to help support and train physicians in practices with 15 or fewer doctors.
- One of the four components of MIPS, resource use, will have a zero percent weighting toward the composite MIPS score in the first year.
- CMS included an option to explore testing of a new Advanced APMs in 2018: Accountable Care Organization ("ACO") Track 1+ and the Diabetes Prevention Program, among others. In early 2016, a provision that would allow participants to participate in new cardiac and orthopedic bundled payment models was also introduced. These models were included in the final rule with public comment with the possibility to qualify as Advanced APMs beginning in 2018.

KEY PROVISIONS OF THE FINAL RULE

Introduction of a Transition Year

Last year, CMS Acting Administrator Andy Slavitt announced in a blog post new options for clinician flexibility that would allow clinicians to "pick their own pace" for participation. These new options were finalized in this rule. If clinicians were ready, they could have begun on January 1, 2017; if they were not ready, they have the option to "test out the program" in the first year by reporting on only one measure *or* by reporting data for 90 days—these clinicians would have an opportunity to qualify for a neutral or small payment adjustment. Clinicians must send in performance data by March 31, 2018.

CMS anticipates that the iterative learning and development period will last longer than the first year, Calendar Year ("CY") 2017, of the program as they move towards a steady state; therefore, they envision CY 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 the second transition year through rulemaking in 2017.*

Merit-Based Incentive Program

CMS estimates that about 500,000 clinicians will be eligible to participate in MIPS in its first year and that MIPS payment adjustments will be equally distributed between negative and positive payment adjustments ($199 million). In addition, positive payment adjustments will include $500 million for exceptional performance for those clinicians whose composite score exceeds 70.

Performance Period

CMS finalized the proposal that MIPS-eligible clinicians have the flexibility to submit information individually or via a group.

For the transition year, clinicians who choose to participate in MIPS can select the pace at which they transition to the program. Under the Final Rule, clinicians can choose one of the following options:

1) *No Participation*. Eligible clinicians may voluntarily elect to not participate in MIPS for 2017. Selecting this option will result in a four percent downward payment adjustment in 2019 to the eligible clinician's Medicare Part B reimbursement.
2) *Test Data Submission*. Test the program by submitting a minimum amount of data—such as one quality measure, one improvement activity or the required advancing care information measures—to avoid a negative payment adjustment.
3) *Partial Data Submission*. Submit 90 days of data, during which a clinician must report more than one quality measure, more than one improvement activity or report more than the required measures in the advancing care information performance category to earn a neutral or small positive payment adjustment
4) *Full Data Submission*. Submit data for all of 2017 to receive a "moderate" positive payment adjustment. For full participation, an eligible clinician needs only to submit data for each of the required MIPS performance categories for a minimum period of 90 continuous days during 2017. An eligible clinician may elect to report data for periods longer than 90 days for 2017, but data submission for all 12 months of 2017 is not required. Under this option, whether an eligible clinician receives an upward, downward or neutral payment adjustment in 2019 will depend on the eligible clinician's performance from scores received in three of the four MIPS performance categories.
5) *Advanced APM Participation*. Participate in an Advanced APM that meets the threshold of sufficient Medicare payments received through the Advanced APM or a sufficient number of Medicare patients through the Advanced APM.

Eligibility

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

The MACRA statute also provides flexibility to specify additional eligible clinicians as MIPS-eligible clinicians in the third and subsequent years of MIPS.

MIPS-Eligible Clinician Identifier

After reviewing comments, CMS will not create a new MIPS-eligible clinician identifier. CMS finalized the proposal to use a combination of the billing Taxpayer Identification Number ("TIN") and National Provider Identifier ("NPI") as the identifier to assess performance of an individual MIPS-eligible clinician. Similar to PQRS, each unique TIN/NPI combination would be considered a different MIPS-eligible clinician, and MIPS performance would be assessed separately for each TIN under which an individual bills.

MIPS-eligible clinicians have the flexibility to submit information individually or via a group. CMS codified the definition of a group to mean a group that consists of a single TIN with two or more eligible clinicians (including at least one MIPS-eligible clinician)—as identified by their individual NPIs—who have reassigned their billing rights to the TIN.

Groups have the option to report at the individual (TIN/NPI) level or the group (TIN) level. Depending on the composition of a group, it may find that reporting at the individual level may be more advantageous for the group than the reporting at the group level and vice versa. Individual eligible clinicians who are not part of a group would report at the individual level.

A group will send in group-level data for each of the MIPS categories through the CMS web interface or an electronic health record, registry or a qualified clinical data registry. To submit data through the CMS web interface, a group must register by June 30, 2017.

Exclusions

Certain subsets of clinicians are excluded from MIPS participation, including: 1) Medicare newly enrolled (first-year) clinicians; 2) clinicians below the low-volume threshold (see below); and 3) certain participants in Advanced APMs.

Low-Volume Threshold

The Final Rule indicates the low-volume threshold has been set at less than or equal to $30,000 in Medicare Part B allowed charges *or* less than or equal to

100 Part B-enrolled Medicare beneficiaries. This is a change from the proposed rule that initially set the low volume threshold at Medicare billing charges less than or equal to $10,000 *and* provide care for 100 or fewer Part B-enrolled Medicare beneficiaries.

Performance Categories and Scoring

As outlined in MACRA, MIPS consolidates three currently disparate Medicare quality programs: 1) PQRS; 2) the Value-Based Modifier Program; and 3) the EHR Incentive Program (Meaningful Use). An additional new category, titled improvement activities, is also added under MIPs. Eligible clinicians will receive a composite score relative to their performance in each of the categories.

The categories are as follows:

1) *Quality, 60 percent of total (up from 50 percent in the proposed rule), replaces PQRS and the quality component of the Value Modifier Program*: For this category, eligible clinicians would report six measures (including at least one outcome measure if available) versus the nine required under the Physician Quality Reporting System (PQRS). An alternative is to report measures in a specialty-specific or subspecialty-specific measure set. If the measure set contains fewer than six measures, MIPS-eligible clinicians will be required to report all available measures within the set. If the measure set contains six or more measures, MIPS-eligible clinicians can choose six or more measures to report within the set.

   A lower threshold of one measure out of six applies for CY 2017. However, groups using the web interface are required to report 15 quality measures for a full year. If your group is in an APM (but not eligible to be in the Advanced APM track of MACRA), your measures will automatically be reported through your APM.

   Quality measures will be selected through an annual process and published in the *Federal Register* by November 1 of each year.

   CMS finalized a weight of zero percent for the Cost performance category, thus increasing the weighting of the Quality component of the composite score to 60 percent for the first year.

2) *Advancing Care Information ("ACI"), 25 percent of total, 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 practices, 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 reduced the number of quality reporting measures from 18 in the current program to five (a reduction from 11 in the proposed rule). Reporting additional measures can, however, help a clinician achieve a higher score. In addition, CMS will award a bonus for any improvement activities that use certified EHR technology (CEHRT) to report to public health or clinical data registries.

The ACI category is made up of a possible 100 points in order to earn a perfect 25 in the overall MIPS composite score. The first 50 points, aka the base score, can be earned by reporting data for the following five required objectives:

- performing a security risk analysis;
- e-prescribing;
- providing patients with access to their data;
- sending a summary of care via health information exchange ("HIE"); and
- requesting or accepting a summary of care.

The other 50 points will be earned from a combination of a clinician's performance percentages in measures of his or her own choosing and/or through bonus points.

The list of objectives also remained the same. The only difference is that the immunization measure is no longer a requirement (as it was in the proposed rule). Instead, it is an optional measure, much like the others that are not listed in the base score above.

CMS also finalized the requirement that MIPS-eligible clinicians, as well as EPs, eligible hospitals and Critical Access Hospitals ("CAHs"), attest to statements that indicate they do not engage in information blocking.

3) *Improvement Activities, 15 percent of total*: This category would reward clinical practice improvements, such as activities focused on care coordination, beneficiary engagement, population management and health equity. In order to meet this category and earn the full 40 points, clinicians must report on four activities (down from six in the proposed rule) for a minimum of 90 days. Groups with fewer than 15 participants or those in a rural or health professional shortage area will need to select only two activities.

As mentioned in the ACI section above, if you choose activities that can be met by using a certified EHR, you will be allowed to earn bonus points in the ACI category.

Participants in certified patient-centered medical homes, comparable specialty practices or an APM designated as a Medical Home Model will automatically earn full credit. Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Program Track 1 or Oncology Care Model, will automatically receive points based on the requirements of participating in the APM.

The finalized improvement activities inventory may be found on page 2,382 of the display version of the Final Rule.

4) *Cost (Resource Use), 0 percent in Year 1*: For this category, the score would be based on Medicare claims, meaning no reporting requirements for clinicians. The cost category will be calculated in 2017, but will not be used to determine payment adjustments. In 2018, CMS will start using the cost category to determine payment adjustments. CMS added that, as performance feedback becomes available from claim analysis, the cost category's contribution to the overall performance score will increase to the statutory 30 percent level by 2021.Clinicians will still receive their scores on how they do in the cost category through their Quality Resource Use Reports.

Composite Performance Score under MIPS

The four performance category scores—quality, resource use (in 2018), improvement activities and ACI—would be aggregated into a MIPS composite performance score ("CPS"). For the transition year, the final score will be compared against a MIPS performance threshold of three points. The final score will be used to determine whether a MIPS-eligible clinician receives an upward MIPS payment adjustment, no MIPS payment adjustment or a downward MIPS payment adjustment as appropriate. Clinicians who achieve a final score of 70 or higher will be eligible for the exceptional performance adjustment.

CMS notes that it may re-weight performance categories if there are not sufficient measures applicable and available to each MIPS-eligible clinician.

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. During the transition year, if clinicians fail to report one measure, they will receive the full negative four percent adjustment.

As specified under the statute, negative adjustments would increase over time, and positive adjustments would correspond. The maximum negative adjustments for each year are: four percent (2019); five percent (2020); seven percent (2021); nine percent (2022 and after).

Virtual Groups

To accommodate smaller practices, CMS allowed for "virtual groups," a MIPS reporting option where up to 10 clinicians combine reporting as one group. However, CMS will not implement virtual groups in the 2017 transition year.

Non-Patient-Facing Physician

MACRA requires CMS, in specifying measures and activities for a performance category, to give consideration to the circumstances of professional types who typically furnish services that do not involve face-to-face interaction with a patient. In the proposed rule, CMS defined a non-patient-facing MIPS-eligible clinician as an individual MIPS-eligible clinician or group that bills 25 or fewer patient-facing encounters during a performance period.

In the Final Rule, CMS modified its position and increased the threshold to a clinician that bills 100 or fewer patient-facing encounters (including Medicare telehealth services) and a group in which more than 75 percent of the NPIs billing under the group's TIN meet the definition of a non-patient-facing individual MIPS-eligible clinician.

Advanced Alternative Payment Models

CMS estimates that about 25 percent of eligible Medicare clinicians could be in an Advanced APM by the second year of the program, which is almost double than what was noted in the proposed rule. It is abundantly clear that CMS wants to move clinicians from MIPS and into the Advanced APM track of MACRA.

APM Incentive Payments

From 2019 through 2024, Qualifying APM Professionals ("QPs") would receive a lump-sum payment equal to five 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.

Requirements for APM Incentive Payments for Participation in Advanced APMs

Qualifying APM Participants are eligible clinicians in an Advanced APM

who have a certain percentage of their patients or payments through an Advanced APM. QPs are excluded from MIPS and receive a five percent incentive payment for a year beginning in 2019 through 2024.

Once in an Advanced APM, clinicians will earn the five percent incentive payment in 2019 for Advanced APM participation in 2017 if:

- they receive 25 percent of their Medicare Part B payments through an Advanced APM Entity, or
- they see 20 percent of their Medicare patients through an Advanced APM Entity CMS finalized its proposal that professional services furnished at CAHs, Rural Health Clinics ("RHCs") and Federally Qualified Health Centers ("FQHCs") that meet certain criteria be counted towards the QP determination using the patient count method.

For performance years 2017 and 2018, the participation requirements apply only to Medicare payments and patients. Starting in performance year 2019, clinicians may also meet an alternative standard for Advanced APMs that will include non-Medicare payments and patients.

Partially Qualifying Participant Threshold

Eligible clinicians who do not become QPs but meet a slightly lower threshold would be deemed Partial QPs for that year. Partial QPs have an opportunity to decide whether they wish to be subject to a MIPS payment adjustment.

In the 2017 QP Performance Period, CMS defined Partial QPs to be eligible clinicians in Advanced APMs who have at least 20 percent, but less than 25 percent, of their payments for Part B covered professional services through an Advanced APM Entity, or who furnish Part B covered professional services to at least 10 percent, but less than 20 percent, of their Medicare beneficiaries through an Advanced APM Entity.

If the Partial QP elects to be scored under MIPS, they would be subject to all MIPS requirements and would receive a MIPS payment adjustment. This adjustment may be positive or negative.

Advanced APM Requirements

The rule finalizes two types of Advanced APMs: Advanced APMs and Other Payer Advanced APMs. To be considered an Advanced APM, an APM must meet all three of the following 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 Other Payer Advanced APMs are virtually the same, but these APMs are intended to be commercial or Medicaid APMs. The Other Payer Advanced APM category is applicable beginning in payment year 2021.

In determining the required nominal risk amount, CMS retracted proposals relating to marginal risk and minimum loss ratio ("MLR") due to their complexity. The Final Rule reduces the nominal amount of financial risk for 2017 and 2018 to either 1) eight percent of the average estimated total Medicare Parts A and B revenues of the participating entity or 2) three percent of the *expected expenditures for which the APM is responsible.*

Advanced Alternative Payment Models

CMS *anticipates* that the following will be Advanced APMs in 2017:

- Comprehensive End-Stage Renal Disease ("ESRD") Care Model (two-sided risk arrangements);
- Medicare Shared Savings Program Track 2;
- Medicare Shared Savings Program Track 3;
- Next Generation ACO Model; and
- Comprehensive Primary Care Plus (CPC+).

The list may change.

Expanded Eligibility Requirements for APM Participation

CMS is exploring an enhanced ACO Track 1+ model for 2018. However, CMS has not laid out the exact requirements for how these programs will be altered in order to meet the high bar being set for qualified Advanced APMs. CMS stated that it will announce additional information about the model in the future.

CMS also intends to revisit the Comprehensive Care for Joint Replacement ("CJR") model. Some commenters suggested that CMS ask CJR hospitals to voluntarily provide a list of eligible clinicians who treat patients in the hospital for any of the CJR procedures to satisfy the Advanced APM Participation List requirement. CMS noted that it considered these comments informally in developing proposed amendments to CJR and will consider public comments in separate rulemaking.

CMS also intends to revisit, with reopened application periods, the Maryland All-Payer Model, the Diabetes Prevention Program and others to expand the options that clinicians have.

Medical Home Standards

Under the Final Rule, 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 rule finalizes criteria for medical home models to ensure that primary care physicians have opportunities to participate in Advanced APMs.

Physician-Focused Payment Models

MACRA establishes the Physician-Focused Payment Model Technical Advisory Committee ("PTAC") to advise CMS on the development and implementation of physician-focused payment models ("PFPMs") that could qualify as APMS or Advanced APMs.

CMS finalized the definition of PFPMs to mean an APM: 1) in which Medicare is a payer; 2) in which eligible clinicians play a core role in implementing the APM's payment methodology; and 3) which targets the quality and costs of services that eligible clinicians participating in the APM provide, order or can significantly influence.

CMS proposed that in carrying out its review of PFPMs, the PTAC shall assess whether the PFPM meets the following criteria:

1) *Incentives: Pay for Higher-Value Care*

   - Value over Volume: Provide incentives to practitioners to deliver high-quality healthcare.
   - Flexibility: Provide the flexibility needed for practitioners to deliver high-quality healthcare.
   - Payment Methodology: Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies and why the Physician-Focused Payment Model cannot be tested under current payment methodologies.
   - Scope: Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.
   - Ability to Be Evaluated: Have evaluable goals for quality of care, cost and any other goals of the PFPM.

2) *Care Delivery Improvements: Promote Better Care Coordination, Protect Patient Safety and Encourage Patient Engagement*
    - Integration and Care Coordination: Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.
    - Patient Choice: Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.
    - Patient Safety: Aim to maintain or improve standards of patient safety.
3) *Information Enhancements: Improving the Availability of Information to Guide Decision-Making*
    - Health Information Technology: Encourage use of health information technology to inform care.

CMS is finalizing its proposed criteria for PFPMs with one modification: broadening the proposed scope criterion. The final scope criterion now requires that PFPMs aim to broaden or expand the CMS APM portfolio by addressing an issue in payment policy in a new way or including APM Entities whose opportunities to participate in APMs have been limited.

KEY TAKEAWAYS/IMPLICATIONS

Industry reaction to the final regulation was generally favorable. Congressional reaction was supportive yet cautious given the size and complexity of the regulation. The House Ways and Means Committee and House Energy and Commerce Committee issued a joint statement expressing support that CMS "responded to many of our concerns and followed our recommendation to provide clinicians and practitioners more flexibility in the issuance of the Final Rule for MACRA."

Some uncertainty still remains about the future of MACRA given the new administration. However, significant legislative changes are unlikely, as MACRA was passed in a highly bipartisan fashion.

Clinicians

For 2017, clinicians will not need to alter their current approaches much to succeed under the Quality Payment Program. Now is the time for clinicians to focus on developing and implementing strategies that will accelerate the transition from volume to value.

In regard to Advanced APMs, although CMS eased the policy defining the

Advanced APM to allow additional programs to qualify and has signaled it will increase the number of available models, the nominal risk standard remains high. These models require significant investment in redesigning care through new technologies, data analytics and additional staff. Whether enough practices will actually transition to Advanced APMS in the future—which is MACRA's overarching goal—is one of the most difficult questions facing CMS.

Manufacturers

APMs and MIPS will increasingly influence care patterns in favor of treatments that improve downstream clinical, financial and patient-reported outcomes. Industry can help physicians understand the programs, their options and how their products fit into the value equation.

Hospitals/Systems

While CMS reduced the burden for clinicians in the Final Rule, it did not adjust for beneficiaries' socioeconomic status within the MIPS measures. This may impact hospitals caring for the nation's must vulnerable patients.

Additionally, APMs and MIPs will require health systems to invest in technology and business practices. CMS requirements will change over time, so systems and processes will need to change with them. Health systems may need to build or acquire special capabilities to succeed under Advanced APMS, such as integrating health information technology across clinicians and the health system to support collaboration.[2]

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[2] CMS MACRA Resources are available at:

- Final Rule: https://qpp.cms.gov/docs/CMS-5517-FC.pdf;
- Executive Summary: https://qpp.cms.gov/docs/QPP_Executive_Summary_of_Final_Rule.pdf;
- Fact Sheet: https://qpp.cms.gov/docs/Quality_Payment_Program_Overview_Fact_Sheet.pdf;
- Small Practice Fact Sheet: https://qpp.cms.gov/docs/QPP_Small_Practice.pdf;
- Comprehensive List of APMs: https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf;
- MIPS and APMs Improvement Activities: https://qpp.cms.gov/docs/QPP_APMs_and_Improvement_Activities.pdf; and
- Quality Payment Program: https://qpp.cms.gov/.