Summary of Centers for Medicare and Medicaid Services Proposed Rule (CMS-5517-P) on Implementing the Medicare Access and CHIP Reauthorization Act of 2015

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On April 16, 2015, Medicare's healthcare financing system was changed in the most significant and far-reaching way since the program's inception in 1965. On that day, President Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

MACRA repealed the flawed Sustainable Growth Rate (SGR) payment system, which governed how physicians and other clinicians were paid under Part B of the Medicare program. MACRA replaced the SGR and its fee-for-service (FFS) reimbursement model with a new system that requires physicians and clinicians to accept downside risk, meaning they would be responsible for a portion of the difference between actual total costs and exceeded budgeted costs. The level of risk providers must accept is substantial, beginning with plus or minus 4% in 2019 and increasing to plus or minus 9% by 2023. MACRA offers providers incentives to more aggressively move into risk through Alternative Payment Models (APMs).

SGR Repeal and Annual Physician Fee Schedule Update

The SGR was created in 1997 and was intended to control the cost of Medicare payments to physicians. Under the formula, if overall physician costs exceeded a target Medicare expenditure, physician payments would be reduced. However, Congress routinely overrode the statutorily required cuts, or "negative update," in what became known as the "doc fix." Neither the Congress nor the physician community was satisfied with the SGR formula in part because it did nothing to address volume or intensity. The formula also did nothing to incentivize quality care.

MACRA Title 1 replaces the SGR formula and from 2015 and through 2019 establishes a 0.5% annual physician fee update. Beyond the annual physician fee schedule update, MACRA creates two new payment tracks for 2019 and beyond: the Merit Based Incentive Payment System (MIPS) formula and the APM pathway.

Like most laws, the statute was drafted in broad terms, leaving much of the implementing details to the Centers for Medicare & Medicaid Services (CMS). On April 27, 2016, CMS published a proposed rule, which gives guidance to providers on how CMS will develop the MIPS and APM tracks. The details, which are outlined below, are proposed and are not final at this time. AMGA anticipates the rule will be finalized this November.

Merit-based Incentive Payment System (MIPS)

In 2019, the MIPS payment formula will consolidate three current programs: the Physician Quality Reporting System (PQRS), the Value-based Modifier (VM) program, and the Meaningful Use program.

These programs will be replaced by new MIPS performance categories on Quality, Resource Use, and Advancing Care Information. CMS is adding a fourth component, Clinical Practice Improvement Activities (CPIA), which will

measure areas such as care coordination, shared decision-making, safety checklists, and expanding practice access. Each performance category will be weighted, and those weights will change over time. Initially, CMS is proposing to weigh Quality at 50%, Advancing Care Information at 25%, Clinical Practice Improvement Activities at 15%, and Resource Use at 10%. Clinicians will receive a score for each category.

For the Quality performance category, providers will select six measures to report, down from the nine required under PQRS. Of the six, one must be an outcome measure and one must be a cross-cutting measure, which are broadly applicable across multiple clinical settings and eligible professionals or group practices within a variety of specialties. Clinicians will have the option to report individual measures or a specialty measure set. The proposed rule includes a list of proposed measures. There are more than 200 measures available and many are designed for specialists.

The Resource Use category, which CMS also refers to as the Cost category, does not include a reporting requirement, as the information will be obtained by CMS from Medicare claims. Resource Use replaces the VM program and it adds more than 40 episode-specific measures. It is expected that the measures that CMS will use for the Resource Use category will be drawn from the existing VM program.

For Advancing Care Information, which replaces Meaningful Use, CMS is proposing to require clinicians to use certified electronic health record (EHR) technology and report on measures that address interoperability and information exchange. The Advancing Care Information score would be made up of a base score and a performance score. For the base score, providers would earn points for reporting on six proposed objectives: protecting patient health, electronic prescribing, patient electronic access, coordination of care through patient engagement, health information exchange, and public health and clinical data registry reporting. For the performance score, clinicians would select the measures that best fit their practice on three proposed objectives that CMS believes emphasizes patient care. These categories of these measures are patient electronic access, coordination of care through patient engagement, and health information exchange.

The last component, Clinical Practice Improvement Activities, is designed to encourage clinicians to engage in a number of activities that CMS contends will improve the patient experience. CMS is proposing a list of more than 90 activities options that are based around the following categories: Expanded Practice Access, Care Coordination, Population Management, Beneficiary Engagement, Patient Safety and Practice Assessment, Achieving Health Equity, Emergency Preparedness and Response, and Integrated Behavioral and Mental Health. CMS is requiring that clinicians select one CPIA activity to report. Additional points in this category may be earned for reporting more activities. In addition, clinicians would receive credit toward scores in this category for participating in APMs and Patient-Centered Medical Homes.

MIPS Performance Adjustment

Each of the four performance categories will be used to calculate a Composite Performance Score (CPS). The CPS will then be used to determine an eligible clinician or group's payment under MIPS. Scoring accommodations will be made for small and rural providers and non-patient-facing providers. Physicians, either independently or in a group, will have their CPS measured against the annually established performance threshold. Scores below the threshold receive a negative payment adjustment, and scores above receive a positive payment adjustment. These adjustments are limited and apply to Medicare Part B payments. For 2019, clinicians will receive a between a positive or negative 4% adjustment. This adjustment increases to 5% in 2020, 7% in 2021, and 9% in 2022 and beyond.

MACRA requires that the overall payment adjustments be budget neutral. This budget neutrality adjustment, also referred to as the scaling factor, may be up to three times the base payment adjustment. Effectively, if in 2019 there are three times as many minus 4% scores as there are plus 4% scores, those providers that score plus 4% could potentially earn a total of plus 12%. This would keep the program budget neutral. The three times

scaling factor applies to the subsequent years, resulting in possible updates of positive 15% in 2020, positive 21% in 2021, and positive 27% in 2022. This scaling factor is only applicable to positive updates. MIPS offers up to $500 million annually (within a top gain limit) to providers demonstrating superior performance.

Providers included in the MIPS performance program for years 2017-2018 are: physicians; physician assistants; nurse practitioners; clinical nurse specialists; and nurse anesthetists. Beginning in 2019 and beyond, other providers subject to MIPS may include: physical and occupational therapists; speech-language pathologists; audiologists; nurse midwives; clinical social workers; clinical psychologists; and dietician/nutrition specialists. Certain providers are excluded from MIPS, including first-year Medicare physician participants and physicians who fall below a low-volume Medicare threshold. CMS is proposing to set this threshold at Medicare billing charges less than or equal to $10,000 and 100 or fewer Medicare patients in one year.

CMS also emphasizes transparency in the MIPS program. To that end, clinicians' MIPS scores will be publicly available on the *Physician Compare* website.

Advanced Alternative Payment Models (APMs)

The second payment track that MACRA creates is the Advanced Alternative Payment Model (Advanced APM). This differs from an APM, which are new approaches to paying for medical care through Medicare that incentivize quality and value, but do not meet the MACRA revenue requirements to be an Advanced APM. Advanced APMs are entities in which clinicians accept downside risk for providing coordinated, quality care. As an Advanced APM, providers assume responsibility for both cost and quality performance using quality measures similar to MIPS and certified EHR technology. Those who meet the rather stringent requirements to qualify as an Advanced APM will earn a 5% Medicare Part B incentive payment. The 5% bonus payment is a lump-sum bonus payment received at the beginning of the year based on the estimated aggregate payment amount for all covered Part B Medicare services for the preceding year.

For years 2019 through 2024, a clinician who meets the law's standards for Advanced APM participation is excluded from MIPS adjustments. For years 2026 and later, a clinician who meets these standards is excluded from MIPS adjustments and receives a higher fee schedule update than those clinicians who do not significantly participate in an Advanced APM.

Under the law, Advanced APMs must bear more than nominal financial risk, base payments on quality measures comparable to those used in MIPS, and use certified EHR technology.

The proposed rule details the nominal risk requirement. CMS is proposing that to qualify as an Advanced APM, the entity must have total risk, or the maximum amount of losses possible, of at least 4% of the APM spending target. The entity also must have marginal risk of at least 30%. This marginal risk represents the percentage of spending above the APM benchmark that is the responsibility of the Advanced APM. CMS also is proposing a minimum loss rate of no more than 4%. This represents the amount of spending that can exceed the APM benchmark before the Advanced APM entity has responsibility for losses.

For the quality measure component, CMS is proposing to require that an Advanced APM must base payment on quality measures that are evidence-based, reliable, valid, and comparable to MIPS. The proposed rule also would require at least one such measure to be an outcome measure, if applicable and available on the proposed list of MIPS quality measures.

CMS also is proposing to require Advanced APMs to use certified EHR technology. The rule propose that an Advanced APM must require that at least 50% of the clinicians use certified EHR technology to document and communicate clinical care information in the first performance year. This requirement increases to 75% in the second performance year.

CMS is proposing to include the following APMs as Advanced APMs: Tracks 2 and 3 of the Medicare Shared Savings (ACO) Program; the ACO Next Generation demonstration; the Comprehensive End Stage Renal Disease (ERSD) Care demonstration; the Comprehensive Primary Care Plus demonstration; and, the Oncology Care Model demonstration. The latter two demonstrations are scheduled to begin in the fall of 2016. Notably, Track 1 ACOs do not qualify as an Advanced APM. In addition, Medicare Advantage plans as currently defined by CMS do not qualify as an APM. However, MACRA requires the Department of Health and Human Services to submit to Congress a report on the feasibility of incorporating APMs in the Medicare Advantage program. However, CMS proposes that MA will be part of the revenue threshold requirements in 2021-2023, provided it meets the other APM criteria.

CMS also is proposing an option for a Medical Home to qualify as an Advanced APM. The rule proposes that a Medical Home Model expanded under CMMI authority can qualify as an Advanced APM. However, CMS is proposing to restrict this option to Medical Homes with no more than 50 eligible participating clinicians. The rule also proposes an alternative financial risk threshold for Medical Homes: For 2017, the threshold is 2.5% of Medicare Part A and Part B revenue. This would increase to 3% in 2018, 4% in 2019, and 5% in 2020.

Earning Bonus Payments in an Advanced APM

The nominal risk, quality measure, and EHR technology requirements address how an entity can qualify as an Advanced APM. To qualify for incentive payments through Advanced APMs, clinicians must meet standards on the amount of payments or the number of patients associated with the Advanced APM. Clinicians will have the option to be assessed as a group to qualify for incentive payments. Those clinicians who meet the requirements are known as qualifying APM participants (QPs). QP determinations will be made at the Advanced APM entity level, and CMS will calculate a percentage threshold score for each advanced APM entity using two methods, payment amount and patient count. QPs determination will be based on whichever measure is more favorable to the clinician.

The payment amount threshold is calculated by dividing the cost for Part B services to attributed beneficiaries by the cost for Part B services to attribution-eligible beneficiaries. To qualify as a QP under the payment amount threshold, CMS is proposing that QPs have a threshold score of 25% in 2019-2020. Beginning in 2021, CMS is proposing to include an "all-payer" option to qualify as an Advanced APM. To qualify under this pathway, in 2021-2022 at least 50% of all revenue must be part of an APM, with at least 25% of it being Medicare revenue. For 2023 and beyond, at least 75% of all payer revenues for services must be provided as part of an APM, with a minimum of 25% coming through Medicare. The patient count threshold is calculated by dividing the number of attributed beneficiaries given Part B services by the number of attribution-eligible beneficiaries given Part B services. CMS is proposing a threshold score for the patient count method of 20% in 2019-2020, 35% in 2021-2022, and 50% in 2023 and onward. CMS is proposing to determine QP eligibility based on the performance in the calendar year that is two years before the payment year. If finalized as proposed, clinicians must meet the QP thresholds for either payment amount or patient amount in 2017 to receive the 5% bonus in 2019.

MACRA also allows for clinicians who are in an Advanced APM but do not meet the thresholds to be a QP. Those who meet slightly reduced thresholds of percent of patients or payments in an Advanced APM are known as Partially Qualifying APM Participants (Partial QPs). Partial QPs have the option to opt out of MIPS and therefore not receive the 5% Advanced APM bonus or a MIPS payment adjustment. They also have the choice to participate in MIPS under more favorable performance category weights. To opt out of the MIPS payment adjustment for 2019 and 2020, CMS is proposing that the clinician must receive 20% of their Medicare payments through an Advanced APM or treat 10% of their Medicare patients through an Advanced APM. In 2020 and 2021, partial QPs would need 40% of their Medicare payments and 25% of their Medicare patients to be through an Advanced APM. For 2023 and beyond, the payment count threshold increases to 50% and the patient count threshold increases to 35%.

Timeframe and the Need to Begin Preparations

Based on CMS' proposed rule, as it is likely the final rule implementing MACRA may change, there are several issues medical groups may consider when preparing for MACRA. To begin, while both MIPS and APM tracks officially begin in 2019, a group's performance period begins in 2017. Consequently, medical groups must prepare to be measured under MACRA in less than 6 months. To make matters more challenging, the final rule implementing MACRA will not be published until November, meaning medical groups will have even less time to prepare. Educating medical group physicians and clinicians as soon as possible about MACRA and its implications for change is important. Reviewing past experience with the PQRS, Meaningful Use, and VM programs will provide guidance how the medical group may perform under MACRA.

For those considering participating as an Advanced APM, similar steps must be taken, with the addition of determining how to meet the payment or patient threshold requirements. Medical groups should consider the positives and negatives of the Advanced APM models listed in the proposed rule, including Next Generation ACO, MSSP Track 2 or 3 programs, or the new CPC+ program. Each of these models has programmatic differences around benefit design and risk exposure which should be considered before selecting an APM. Accurate coding practices must be implemented to ensure claims reflect the complexity of the group's patient population. Reviewing data on emergency department visits, admissions and post discharge processes is critical, as is assessing post-acute provider relationships. Understanding the group's ability to contract with Medicare Advantage (MA) plans may help ensure meeting the threshold requirements in 2021 and 2023, assuming MA plan revenues are allowed to be considered part of the threshold calculation.

For more information, visit our MACRA web page at amga.org/macra. AMGA members may email their MACRA and risk- related questions to macra@amga.org