# MACRA, MIPS, and Advanced APMs: Time to Prepare

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On April 27, 2016, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule titled "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."[1]

This 962-page document provides detailed information on how Medicare proposes to oversee and manage two programs that were created in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). These are the newly created Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (APMs).

This article will review selected aspects of the proposed rule so clinicians can begin preparing for MIPS and Advanced APMs, which go into effect on January 1, 2017. The need to start preparing now is vital.

The final rule on these topics is not scheduled until November 2016. Waiting for the final rule would not provide for sufficient time to prepare for MIPS and Advanced APMs. Many preliminary decisions will need to be made based on the proposed rule and statutory language contained in MACRA.

## Background on the Rule

MACRA received strong bipartisan support in Congress as it repealed the Sustainable Growth Rate (SGR) payment formula that increasingly reduced Medicare payments to clinicians. It was signed into law by President Obama in April 2015. However, MACRA also replaced the SGR with MIPS and Advanced APMs, which serve as an alternative to MIPS.

Eligible clinicians impacted by MIPS and Advanced APMs include physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. At this time MIPS does not apply to hospitals or facilities, although CMS is considering applying many of the same principles to acute care settings in the near future. Eligible clinicians may report as individuals or as groups.

## Information on the Merit-based Incentive Payment Program (MIPS)

MIPS consolidates reporting under three existing Medicare programs: Physician Quality Reporting System (PQRS), Value-based Modifier (VM) and Meaningful Use of Certified Electronic Health Record Technology (CEHRT). These have been replaced by four performance categories: quality (formerly PQRS), resource use (formerly VM), advancing care information (formerly the Meaningful Use of Certified EHR Technology), and clinical practice improvement activities (CPIAs) (a new performance category).

Medicare will factor in performance data reported from each eligible clinician or group practice and determine a "Composite Performance Score" (CPS) for each eligible MIPS clinician or group. The CPS will range from zero to 100 points, and the influence of each performance category on the CPS will vary over the first few years of the MIPS.

For the 2017 performance year, the following category weights will apply:

- Quality Measure Reporting: 50 percent. Users must report on a minimum of six MIPS quality measures, many of which are identical or nearly identical to PQRS measures. At least one of the measures must be considered "cross-cutting," as defined by Medicare. Cross-cutting measures are defined by CMS as "any measures that are broadly applicable across multiple clinical settings and eligible professionals (EPs) or group practices within a variety of specialties.[2] One of the

most significant changes to quality reporting associated with MIPS is that the program no longer has a "all-or-nothing" reporting requirement, as it was under the PQRS and Meaningful Use programs.

- Advancing Care Information: 25 percent. This is being viewed as a simplified version of Meaningful Use and is based upon the provider's ability to demonstrate the use of certified electronic health record (EHR) technology on objectives and measures proposed under modified Stage 2 Meaningful Use in 2017 or Stage 3 Meaningful Use in 2017 and later years depending on whether the eligible clinician has adopted the 2014 or 2015 Edition of certified EHR technology . There is a significant emphasis on interoperability.
- Clinical Practice Improvement Activities (CPIAs): 15 percent. CPIAs include expanded practice hours and other efforts that improve patient care, patient safety, and utilization. CMS will make publically available a list of medium and highly ranked CPIAs.
- Resource Use: 10 percent. Medicare will use claims data and determine attributed expenditures per eligible clinician in both Medicare Part A and Part B. No data submission is needed by clinicians. This performance category is very similar to the Medicare VM program, and information about expenditures per provider has been tracked for many years. However, in the past this performance data remained confidential.

The proportional weighting of each performance category could change over time—for example, resource use will increase to 30 percent of the CPS over a period of several years and quality will decrease to as low as 30 percent.

After an eligible clinician's or group's composite performance score is determined, this score will be compared to the MIPS performance threshold as determined by CMS. A CPS below or above the performance threshold will yield a payment adjustment of +/- 4 percent in 2019, based on performance data submitted in 2017. The payment adjustment percentage will increase over the next 3 years to +/- 9 percent in 2022 and afterwards.

However, MIPS is also what is referred to as a "budget neutral" program. This means that total upward and downward adjustments must be balanced so the average change is zero percent. In other words, an eligible clinician or group who is eligible for a positive adjustment under MIPS has the potential to earn three times their anticipated payment adjustment. For instance, an eligible clinician that receives a +4 percent adjustment for MIPS could receive up to +12 percent in 2019.

CMS estimates that as many as 90 percent of eligible clinicians will be in the MIPS program in 2017 and as few as 10 percent will be in an Advanced APM. They anticipate that the number of eligible clinicians enrolled in Advanced APMs will increase over time. As noted above, data reported in 2017 under the MIPS program will be used to determine the first CPS, which CMS estimates will average around 60 points. The CPS for the 2017 performance year will be published, along with a breakdown of performance under each of the four performance categories of MIPS, on the Physician Compare website managed by CMS in late 2018.

The CPS data will be available to the public, including patients. This aspect of MIPS may be a significant driver of clinician behavior, as it could impact a provider's ability to recruit and retain patients, both positively and negatively.

# Information on Advanced APMs

In order to be excluded from MIPS payment adjustments eligible clinicians may elect to enroll in an Advanced APM. Clinicians that meet the requirements of being a qualified participant (QP) in an Advanced APM will avoid the MIPS payment adjustments, and receive a 5 percent upward adjustment for Medicare payments between 2019 and 2024. There are currently a number of APMs, but only advanced APMs will allow QPs to receive the annual 5 percent bonus and automatically exclude them from the MIPS. From 2026 and onwards, QPs qualify for additional upward payment adjustments of 0.75 percent per year. Advanced APMs may have limited enrollment initially given that a relatively small number of programs will qualify as Advanced APMs. At this time CMS has identified only six APMs that qualify as Advanced APMs out of 24 selected APM examples.

These include:

1. Comprehensive End-Stage Renal Disease Care
2. Comprehensive Primary Care Plus
3. Medicare Shared Savings Program – Track 2
4. Medicare Shared Savings Program – Track 3

5. Next Generation ACO Model
6. Oncology Care Model (two-sided risk arrangement)

CMS has also stated that it will offer certification to Patient-Centered Medical Homes that quality as Advanced APMs, although this program is evolving. CMS will identify APMs that qualify as Advanced APMs by January 1 of each performance year. Eligible clinicians may also achieve status of "Partially Qualifying Participants" based on patient volume and spending thresholds. These providers will be given the opportunity to opt out of the MIPS and its associated payment adjustments.

# Additional Components of the Proposed Rule

Additional aspects of the proposed rule include health information technology (HIT) testing for compliance with certification requirements. The Office of the National Coordinator for Health IT would have the authority to suspend or terminate the certification status of HIT products that are identified as failing to meet criteria. How this would impact providers using this type of technology is a topic of concern to a number of groups. Medicare is seeking input from stakeholders on this and other aspects of the proposed rule, and clarifications are expected in the final rule later this year.

Other select considerations clinicians should examine from the rule include:

1. **Timelines:** The MIPS and Advanced APM programs start, as proposed, on January 1, 2017. The proposed rule was released in April but it and MACRA represent the most specific information available on these programs until the final rule is released, most likely in late October or November 2016. It should be noted that the proposed and final rules do not have the legal authority to change statutorily defined aspects of MIPS and Advanced APMs in MACRA. Healthcare stakeholders with significant Medicare Part B patient populations will need to start preparing. Those who will likely be in the MIPS program may wish to evaluate how to optimize their measure performance (e.g., strive to document that smoking cessation counseling was performed for 100 percent of patients under their care). MIPS participants may also wish to review the CPIAs presented by CMS in the proposed rule and start planning for their implementation.
2. **Effect on Small Practices:** Given the need for practices to engage skilled resources to achieve high measure capture rates in EHR platforms, it may be difficult for solitary or small group practices to stay on top of the technical aspects associated with data reporting through EHRs. Economies of scale allow larger organizations to support skilled labor with expertise in quality reporting, potentially placing smaller practices at a disadvantage. To counter this CMS has proposed funding to assist small practices (defined as 15 or fewer physicians), in particular in rural and disadvantaged areas, that may occur through Regional Extension Centers and other third parties. However, training may not be adequate for some smaller practices that may require ongoing support from knowledgeable professionals to achieve high levels of performance.
3. **Influence of the CPS:** Having a performance score publically displayed may or may not significantly influence provider behavior; however, it may be fair to say that most providers would prefer to see scores that are as high as possible. The impact of a low CPS on the ability of a practice to retain and recruit patients has yet to be determined, although very low performance scores may generate concern amongst patients. The concept that essentially 50 percent of clinicians are "below average" based on their CPS performance is also somewhat unique, and overall may not be an ideal method for representing clinician capabilities to patients. However, this is a statutory requirement under MACRA.
4. **Effect of Payment Adjustments on Physicians Willing to Accept New Medicare Patients:** Providers that do not participate in MIPS or Advanced APMs will receive a CPS of zero and be subjected to the maximum negative payment adjustment, which will reach negative 9 percent by 2022. Providers subjected to these payment adjustments, which last an entire year, may not be inclined to enroll new Medicare patients over patients insured by different payers. This could potentially decrease the total number of physicians willing to take Medicare patients during a period in which the Medicare population will be growing substantially.

# Comment Now on the Proposed Rule

CMS is seeking input on the proposed rule through June 27, 2016 and stakeholders are invited to contribute their questions, concerns, and recommendations. Although CMS has authority to develop specific policies and methodologies, the majority of the core features of the MIPS and Advanced APMs are required by statute (i.e., they are specified by MACRA). Unless

MACRA is modified by congressional action, MIPS and Advanced APMs, including the CPS and potential payment adjustments, will go into effect in January 2017.

At this point it may be advisable to use MACRA and the proposed rule to prepare for 2017. This will position practices to engage newly defined requirements in the final rule once it is released.

# Notes

[1] Centers for Medicare and Medicaid Services. "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 (Proposed Rule)." April 27, 2016. https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf.

[2] Centers for Medicare and Medicaid Services. "Frequently Asked Questions: What are cross-cutting measures in Physician Quality Reporting System (PQRS) and how do face-to-face encounters trigger possible reporting of a cross-cutting measure?" https://questions.cms.gov/faq.php?id=5005&faqId=12168.

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