MACRA Proposed Rule: A Deeper Dive into Medicare's New Physician Payment System

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On April 27, 2016, the Centers for Medicare and Medicaid Services (CMS) unveiled a proposed rule to implement certain provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The much-anticipated proposed rule is the first formal regulatory step necessary to implement MACRA's dramatic physician payment reforms.

Comments on the proposed rule will be accepted through June 27, 2016. A final rule will be posted by November 1, 2016 in advance of the first performance year beginning January 1, 2017.

This paper is a detailed and comprehensive summary that supplements our shorter overview summary published on May 3, 2016. This paper is intended to serve as a resource for those seeking to become familiar with the nuts and bolts of the proposed rule. Members of Hooper, Lundy & Bookman's Medicare Physician Payment Working Group[1] prepared the following comprehensive overview, divided into the following sections:

1. Background and Overview
2. Merit-based Incentive Payment System
3. Alternative Payment Models
4. Physician-Focused Payment Models
5. Program Timeline Summary
6. Preliminary Takeaways

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1. Background and Overview:

MACRA was enacted after several years of short-term "fixes" to prevent payment cuts under the previous sustainable growth rate (SGR) formula. The legislation was a bipartisan, bicameral effort to move towards Medicare payment based on value, rather than volume. This legislation passed with the support of many health care stakeholder organizations, which will now watch carefully as the Centers for Medicare and Medicaid (CMS) implements this massive change to Medicare Part B payment to ensure a smooth transition and optimum outcomes of participation for as many clinicians as possible.

MACRA repeals the Medicare SGR and replaces it with the Quality Payment Program (QPP), a two track system including: 1) a Merit-based Incentive Payment System (MIPS) for eligible professionals under the Physician Fee Schedule(PFS); and 2) optional participation in Advanced Alternative Payment (APM) models. The implementation of these programs will impact not only clinicians, but also the facilities and networks they practice within.

2. Merit-based Incentive Payment System (MIPS):

Beginning with the 2019 payment year, MACRA combines the three current performance payment adjustments under the Physician Quality Reporting System (PQRS) the Value-based Payment Modifier (VM) and the Medicare EHR Incentive Program and establishes MIPS as the single quality payment system. However, the payment adjustments that start in 2019 would be based on the data they submit for the performance period starting January 1, 2017, and ending December 31, 2017. As a practical matter, this means that most clinicians will be subject to MIPS in the first couple of years, as only a minority will be in an Advanced APM in the near term. Those eligible clinicians (ECs) who do not meet at least the criteria of a Partial Qualifying Participant (QP) in an Advanced APM will automatically be subject to MIPS.

MIPS evaluates eligible clinicians using a composite performance score across four domains:

- Quality;
- Resource use;
- Clinical practice improvement activities (CPIA) and
- Advancing care information.

Clinicians in the Advanced APM track will be subject to a similar set of performance metrics. MIPS eligible clinicians also participating in APMs will receive favorable scoring under certain MIPS categories.

a. Data Submission Process

Under the proposed rule, MIPS data may be submitted on behalf of clinicians through various potential third party vendors: a qualified registry; a Qualified Clinical Data Registry (QCDR); a health IT vendor that obtains data from the eligible clinician's certified EHR technology (CEHRT); or, a CMS-approved survey vendor. The proposed rule outlines specific requirements for each category and allows CMS to place a third party vendor on probation and/or disqualification for not meeting all applicable requirements for qualification.

b. MIPS Eligible Clinicians

In years 1 and 2 (payment years 2019 and 2020), eligible clinicians include:

- physicians (MD/DO and DMD/DDS);
- physician assistants (PAs);
- nurse practitioners (NPs);
- clinical nurse specialists (CNSs); and
- certified registered nurse anesthetists (CRNAs).

In the third year and beyond, the Secretary of Health and Human Services may add other clinicians and has indicated a willingness to do so in the proposed rule. Of these eligible clinicians, several categories of providers are proposed to be excluded from the definition of a MIPS eligible clinician. New Medicare-enrolled eligible clinicians are not considered MIPS eligible clinicians until they have been enrolled for a full year of a performance period.

Also, those clinicians who meet the definition of a Qualifying Participant in an Advanced APM or Partial Qualifying Participant, choosing not to report under MIPS, will not be included in the MIPS system. Further, the definition does not include MIPS eligible clinicians who are below the low-volume threshold for a given year. As proposed, a clinician with Medicare billing charges less than or equal to $10,000 *and* who provides care for 100 or fewer Part B-enrolled Medicare beneficiaries, would be deemed "low-volume" and not eligible for MIPS. Based on these exclusions, CMS estimates that between approximately 687,000 and 746,000 clinicians will be subject to MIPS for 2019.

i. Special Cases

The proposed rule addresses the unique circumstance of several categories of providers. For example, the proposed rule recognizes that Non-Patient-Facing MIPS Eligible Clinicians (such as anesthesiologists, pathologists and radiologists) will not have sufficient measures and activities applicable to report under certain MIPS performance categories. CMS proposes to follow an approach similar to that in PQRS, setting a threshold of 25 or fewer patient-facing encounters, such as office visit claims. Furthermore, for MIPS eligible clinicians who practice in critical access hospitals (CAHs) which bill under Method I and Method II, would be subject to MIPS if they do not assign their payments to the CAH. In those cases of non-assignment, the CAH would not be subject to the adjustment. Likewise, for MIPS eligible clinicians who practice in rural health clinics (RHCs) and/or Federally Qualified Health Centers (FQHCs), who bill for services under the RHC/FQHC all-inclusive rate, the MIPS adjustment would not apply. However, if the clinician bills separately under the PFS and meets the minimum thresholds, MIPS would apply to payments made for items and services billed by MIPS eligible clinicians under the PFS.

ii. Groups

The rule proposes that there be multiple ways for individual MIPS eligible clinicians to have their performance assessed as a group. The group must meet the proposed definition of a group at all times during the performance period for the MIPS payment year. A group that elects to have its performance assessed as a group would be assessed as a group across all four

performance categories. MACRA also established the use of voluntary virtual groups for certain assessment purposes, however CMS proposes to defer implementation of virtual groups to 2018 due to administrative challenges.

c. MIPS Performance Categories

Beginning with the 2019 payment year, CMS proposes to weight the performance categories to accommodate for the transition to new measures. In the second year, the resource use weighting will increase and the quality category weighting will decrease. The proposed performance weighting in year 1 is:

- Quality (50%)
- Resource Use (10%)
- CPIA (15%)
- Advancing Care Information (25%)

i. Quality

Under the quality performance category of MIPS, clinicians are incentivized to engage in improvement measure and activities that have a proven impact on patient health and safety for their relevant patient populations. CMS has attempted to provide flexibility in the proposed rule by eliminating redundant measures, allowing eligible clinicians to choose measures that are meaningful to their practice, has provided measure sets by specialty, and has decreased the amount of required measures to report.

A MIPS eligible clinician who fails to report on a required measure or activity will be treated as achieving the lowest possible score for that measure or activity. For each applicable 12-month performance period, the MIPS eligible clinician or group will report at least six measures, including one cross-cutting measure (if patient-facing) and at least one outcome measure. CMS is considering an option for facility-based MIPS eligible clinicians to elect to use their institution's performance rates as a proxy for the clinician's quality score.

Each year, the Secretary will solicit new measures and the annual list of quality measures will be published in the Federal Register no later than November 1 of the year prior to the first day of a performance period.

ii. Resource Use

The resource use or "cost" category will compare applicable resources used to treat similar care episodes across practices. Because the resource use performance category relies on Medicare administrative claims data, no separate reporting by clinicians will be required.

For year 1 (2019), CMS proposes to use the following measures to assess the performance use of MIPS eligible clinicians:

- Total per capita cost;
- Medicare Spending Per Beneficiary (MSPB); and
- Several episode-based measures.

CMS proposes to weigh all of the measures equally within the resource use performance category, and all of the measures would be adjusted for geographic payment rate adjustments and beneficiary risk factors. CMS anticipates that most MIPS eligible clinicians will be familiar with the MSPB and total per capita cost measures from the VM program. CMS proposes 41 clinical condition and

treatment episode-based measures for the third criterion above, to address various specialties.

iii. Clinical Practice Improvement Activity (CPIA)

CPIA will be scored based on participation in at least one of over 90 proposed activities for at least 90 days during the performance year. The highest CPIA score weightings will be given for participating in nationally recognized accredited patient-centered medical homes (PCMH), including the Medicaid Medical Home Model and the Medical Home Model. A minimum of half credit will be given to those participating in APMs. To receive credit, an eligible clinician must participate in at least one activity with the opportunity for additional credit by participating in more activities throughout the performance year.

Groups choose which CPIA activities to report to CMS. Based on which activities are reported as being performed, CMS determines the score. CMS indicates that it plans to increase the performance standards over time. Proposed CPIA sub-categories include population management, care coordination, beneficiary engagement, patient safety and practice assessment, and participation in an APM.

iv. Advancing Care Information (ACI)

Perhaps the most anticipated change in the proposed rule was the streamlining of the current EHR meaningful use program to provide for greater flexibility to encourage adoption of certified EHR technology (CERHT). The proposed rule seeks to improve the program for clinicians by adopting a new, more flexible scoring methodology. The new methodology puts a greater emphasis on patient electronic access, coordination of care through patient engagement, and health information exchange. The proposal seeks to change the program from an "all or nothing" approach, to one based on performance and the ability to choose measures meaningful to each clinician's practice. To accommodate providers who have not been reporting under EHR meaningful use program, CMS proposes to make this category optional in 2017 for NPs, PAs, CNSs, and CRNAs.

There are three parts to the ACI requirements: a threshold requirement to protect electronic protected health information (ePHI); a base score, including e-prescribing, patient electronic access, patient engagement, health information exchange and data registry reporting; and an additional set of eight measures which can add to the overall performance score. The eight proposed measures for the performance score are:

- Patient access;
- Patient-specific education;
- View, Download, and Transmit (VDT);
- Secure messaging;
- Patient-generated health data;
- Patient care record exchange;
- Request/accept patient care record; and
- Clinical information reconciliation.

Under MIPS, CMS proposes to align the performance period for the advancing care information performance category to the proposed MIPS performance period of one full calendar year. For 2017, MIPS eligible clinicians may use EHR technology certified to either 2014 or 2015 criteria. For 2018, MIPS eligible clinicians must use EHR technology certified to 2015 criteria. In addition to the interfaces already available for data submission, CMS will make a web interface available for data submission beginning in 2017. Under the proposed rule, groups of eligible professionals may be assessed and reported at the group level, as opposed to the MIPS eligible clinician level. CMS expects this to lessen the reporting burden. It has been noted that this change is only applicable to eligible clinicians, and does not change the current EHR MU program for hospitals. It is likely there will be efforts to align this in the future.

v. Special Cases

CMS will provide for reweighting of the category for certain types of practitioners. Among those discussed are hospital-based clinicians and clinicians who do not have face-to-face contact with patients. For such practitioners, CMS proposes to reweight the category to 0 percent. CMS also proposes an application process for reweighting in appropriate cases. This would also apply to those clinicians who have the option of reporting in 2017.

b. APM Scoring Standard for MIPS Eligible Clinicians

Qualifying Advanced APM Participants (QPs) are not MIPS eligible clinicians and are therefore excluded from MIPS payment adjustments. Partial Qualifying APM Participants (Partial QPs) are also not MIPS eligible clinicians unless they opt to report and be scored under MIPS. Consequently, CMS has proposed in the rule to establish a scoring standard for MIPS eligible clinicians participating in certain types of APMs in order to streamline reporting for those individuals participating in APMs who may not reach the threshold amount of an *Advanced* APM. For purposes of this scoring standard, CMS proposes to consider eligible clinicians at the entity APM entity level. This standard would aggregate all eligible clinicians' MIPS scores to establish one score for all clinicians in the APM entity.

CMS has proposed that the APM scoring standard under MIPS would only be applicable in the case of an APM entity that meets the following criteria:

- It participates in the APM under an agreement with CMS;
- It includes one or more MIPS eligible clinicians; and
- The APM bases payment incentives on performance on cost/utilization and quality measures.

The scoring performance period would be the same as the period generally applicable to MIPS. To assist individuals participating in APMs with this scoring standard, CMS has proposed alternative weighting of performance categories that will be based on the APM model design. In

addition, under certain models, CMS proposes to allow the entity to submit quality data on behalf of its clinicians to ease the burden of reporting. CMS has indicated the following models would qualify for this alternate scoring standard:

- Shared Savings Program (all tracks);
- Next Generation ACO Model;
- Comprehensive ESRD Care (CEC);
- Comprehensive Primary Care Plus (CPC+);
- Oncology Care Model (OCM); and
- All other APMs that meet criteria for the APM scoring standard.

b. MIPS Composite Performance Scoring Methodology

The MIPS performance scoring methodology is intended by CMS to promote accountability and alignment across performance categories while minimizing reporting burdens on MIPS eligible clinicians. CMS proposes to utilize a unified scoring system for the four performance categories (Quality, Resource Use, CPIA & Advancing Care Information) in an effort to keep scoring as simple as possible and still provide flexibility for different practice settings and reporting options. For the Quality and Resource Use reporting categories, measures would be scored on a 10-point scoring system to enable universal comparison across different measures and practice specialties.

i. Scoring Quality

Generally, for a particular quality performance measure, a clinician will be awarded a score ranging between 1 to 10 points. In order to be scored, the clinician will need to meet a case minimum (20 cases, except for the all-cause hospital readmission measure). Failure to submit information on a required measure will result in a score of 0. Clinicians' performance will be measured against benchmarks for reported measures. The specific benchmarks will be computed based on historical performance during the baseline period. If baseline data is not available (or there has been a significant change in the measure) the benchmarks will be determined using performance period data. CMS proposes to exclude benchmark data from clinicians that report measures with a performance of 0 due to concerns that these clinicians could be erroneously submitting this data.

To encourage the reporting of high priority measures, CMS proposes to provide bonus points to clinicians (2 points for each outcome and patient experience and 1 point for other high priority measures) who report high priority measures above and beyond high priority measures already required to be reported. CMS proposes to cap the bonus points awarded for high priority measures at 5% of the denominator of the quality performance category score. In addition to the high priority bonus, CMS will separately award 1 bonus point for the use of CEHRT by clinicians to report quality measures, which would also be subject to a 5% cap.

During the first year of MIPS no improvement points will be awarded. Thereafter, CMS is considering three possible options for awarding improvement points. One possible approach is to award improvement points (1-9) with the final score being the higher of the achievement score or the improvement score. Another possible approach would be to use the

approach used in the Medicare Shared Savings Program (MSSP) in which up to four bonus points are awarded based upon a clinician's net improvement. The final possible approach is to use a program star-rating program akin to the approach used in the Medicare Advantage program.

ii. Scoring Resource Use

CMS proposes to use a similar scoring system to the proposed quality performance scoring system (with benchmark deciles and achievement points from 1-10 awarded). In this category, lower costs mean better performance so the clinicians with the lowest resource use would achieve the highest scores. CMS proposes to use a 20 case minimum for each resource use measure. In calculating the score, CMS proposes to average the scores of all of the resource measures (giving them all equal weight).

iii. Scoring Clinical Practice Improvement Activities

In this category, by statute, eligible clinicians who practice in nationally certified PCMH or comparable specialty practice must receive the highest potential score for this category. Moreover, clinicians who participate in an APM for a performance period may not receive a score lower than one half of the highest potential score for the category.

CMS proposes two categories of activity measures: medium-weighted activities (worth 10 points each) and high-weighted categories (worth 20 points each). Since CMS believes that clinicians will be able to report on as many as six medium-weighted categories, CMS proposes that the highest potential score for the CPIA category be 60 points. CMS proposes some adjustments in the scoring of this category for certain practices, such as top performing small practices (15 or fewer clinicians) or practices in rural or health professional shortage areas. As with scoring in the previous categories, CMS proposes to calculate the CPIA category score by dividing the sum of all points earned by the maximum 60 possible points.

iv. Scoring Advancing Care Information

Scoring for this category includes both a base score (for participation) and a performance score. The base score (with a maximum score of 50%) would be earned by clinicians reporting certain measures adopted by EHR Programs in the 2015 EHR Incentive Program Final Rule. The performance score (with a maximum score of 80%) would be scored similar to the quality performance and resource use category scoring methods. The maximum score for this category is 100% with the excess (from the two scores) included by CMS to provide clinicians with the flexibility to achieve the maximum score. There is also a bonus point for clinical registry data reporting.

v. Calculating the Composite Performance Score

The composite performance score (CPS) would be calculated by multiplying the score for each performance category by the weight assigned in the statute to that category. CMS also proposes some flexibility to redistribute the weight in specific categories under certain

circumstances, such as when a clinician does not receive a score for a performance category or where there are insufficient quality measures. CMS proposes that individual clinician composite scores and performance scores be included on Physician Compare, as well as aggregate information on the range of MIPS composite scores and range of performance by category.

vi. MIPS Payment Adjustments

For payment adjustments, CMS proposes to use the CPS that is associated with the Taxpayer Identification Number/ National Provider Identifier (TIN/NPI) combination in the performance period. For those reporting as a group, the CPS would be applied to all TIN/NPI combinations that bill under the TIN during the performance period. CMS proposes to use a weighted average CPS for situations in which more than one TIN was used during a performance period. For situations in which a TIN/NPI may have more than one CPS, CMS proposes to resolve the issue by using the APM entity's CPS (in cases in which the clinician participates in an APM) and to resolve conflicts (whether they be between multiple APMs or group vs. individual) by using the highest CPS.

Clinicians' MIPS payments may be adjusted (positively or negatively) based on whether they score above or below the performance threshold. The MIPS adjustments generally must be budget neutral such that the amount of negative adjustments must be equal to the number of positive adjustments. Budget neutrality does not apply, however, if all clinicians receive a negative adjustment. For payment years 2019 through 2024, an additional positive adjustment of $500 million will be distributed each year to those clinicians who perform above the additional performance threshold. However, individual clinicians are subject to a 10% additional bonus cap and therefore the entire $500 million may or may not be distributed.

For 2019, CMS proposes to use a sensitivity analysis to determine where the performance threshold is set, with approximately 50% of the clinicians above the threshold and the remaining 50% below. For eligible clinicians with exceptional performance, CMS will establish an additional threshold equal to the 25th percentile above the performance threshold. Those that meet the exceptional performance threshold would be eligible for an additional adjustment of up to 10%. Payment year 1 (2019) will be based on a performance year two years prior (2017). CMS will make MIPS payment adjustments no later than 30 days prior to January 1 of the payment year.

For payment year 2019, the proposed rule estimates it will distribute $833 million in MIPS payment adjustments on a budget-neutral basis, and $500 million in exceptional performance payments under MIPS. CMS estimates that approximately 54 percent of MIPS-eligible clinicians will receive a positive adjustment, while 46 percent will receive a negative adjustment. In practice, these proportions are expected to vary by specialty and by practice size, with positive adjustments increasing with size of practice. CMS estimates that more than 81 percent of eligible clinicians in practices of 100 or more (there are estimated to be 248,626 clinicians in this

category) will receive a positive MIPS adjustment. In contrast, CMS estimates that 87 percent of eligible clinicians in solo practices (approximately 89,383 clinicians) will receive a negative adjustment in 2019.

3. Advanced Alternative Payment Models:

a. Qualified Participants and Advanced APMs.

Between 2019 and 2025, eligible clinicians who participate in certain Advanced APMs will be excluded from the MIPS program and will be eligible to receive an annual lump sum incentive payment equal to 5% of their prior year's payments for Part B covered professional services. Starting in 2026, qualified participants will receive higher annual fee schedule update than eligible clinicians participating in the MIPS program – a .75% increase rather than the standard .25% increase for MIPS participants. CMS uses the term "Advanced APM" in order to differentiate non-qualifying APMs that do not satisfy the required elements laid out in MACRA and the proposed rule (e.g. ACOs without down side risk). Individual eligible clinicians who participate in qualified Advanced APMs are identified in the proposed rule as qualifying participants (QPs).

b. Prerequisites for Advanced APM Designation

Not all APMs will qualify as Advanced APMs—a source of some controversy, and expected to be the subject of many comments. In fact, CMS has indicated that many clinicians currently working in APMs may not qualify in the first performance year. Using participation rates in APMs in 2014, CMS estimates a lower bound of 30,658 QPs (with associated incentive payments of approximately $146 million) in the 2017 performance year.

Based on the introduction of new APMs since 2014 and expected increased participation in existing APMs, CMS estimates an upper bound of 90,000 QPs (with corresponding incentive payments of $429 million) in future years. MACRA sets out the following criteria APMs must satisfy in order to be considered an Advanced APM:

- The APM must require participants to use CEHRT;
- The APM must provide for payment for covered professional services based on quality measures comparable to those in the quality performance category under MIPS; and
- The APM must either require that participating APM entities bear risk for monetary losses of a more than nominal amount or be a Medical Home Model expanded under CMS Innovation Center authority.

Similar standards will apply for Other Payer Advanced APMs (meaning Advanced APMs where Medicare is not the payer), although CMS will not begin identifying Other Payer Advanced APMs until 2019.

i. Certified EHR Technology

For purposes of the APM CEHRT requirement, CMS has proposed to adopt the same definition of CEHRT that is being proposed for the MIPS program. In order to qualify as an Advanced APM during the initial performance period, the APM must require that at least 50% of its eligible clinicians use CERHT. This requirement is increased to 75% participation after the first performance year.

ii. MIPS Comparable Quality Measures

To qualify as an Advanced APM, an APM must base payment on quality measures *comparable* to the quality measures required under the MIPS program. CMS states that this means measures must be evidence-based, reliable and valid. The intent is to create a standard that is somewhat flexible and recognizes that APM entities will have different priorities and objectives. An APM that ties payments to performance based on quality measures may be considered an Advanced APM regardless of how the APM or its clinicians actually perform on the quality measures.

iii. Financial Risk for Monetary Losses

CMS provides two standards that must be met in order to satisfy the financial risk in the proposed rule. These standards are higher than many clinicians had expected or hoped for in order to increase participation in APMs. First, for the financial risk standard, Qualifying Advanced APM entities must bear risk for monetary losses if actual expenditures exceed expected expenditures during the applicable performance period. CMS clarified that this means CMS must be able to take one of the following actions against the APM entity:

- Withhold payment for services;
- Reduce payment rates; and/or
- Require repayment of amounts in excess of expected expenditures.

Second, under the nominal amount standard, not only must qualifying Advanced APMs bear financial risk, but the amount at risk must be more than a "nominal" amount. CMS proposes that in order to determine whether the level of risk satisfies the nominal risk standard, it will review three different components of risk:

- The marginal risk or the percentage of over budget payments the APM would be required to repay;
- The minimum loss ratio or the amount that actual expenditures could exceed expenditures before triggering a repayment obligation; and
- The total potential risk or the maximum total potential payment for which the APM could be liable.

CMS proposes establishing limits on each component of risk. Specifically, the amount at risk must be a least 4% of expected expenditures, the marginal risk must be at least 30% and the minimum loss ratio must be no more than 4%.

The proposed rule contains a different financial risk standard for Medical Home Models; namely, that the amount the entity owes CMS must meet specific thresholds during relevant performance years. The proposed risk threshold starts at 2.5% in 2017 and eventually reaches 5% for 2020 and later years.

c. Advanced APMs Determination and Advanced APMs Available in 2017

In the proposed rule, CMS indicates that it will release an initial set of Advanced APM determinations applicable to the first QP performance period no later than January 1, 2017. For determinations made after January 1, 2017, CMS indicates that it will make public announcements via its website at least annually. Based on the proposed criteria, CMS has confirmed that the following APMs would be considered Advanced APMs in 2017:

- Medicare Shared Savings Program (Tracks 2 and 3);
- Next Generation ACO Model;
- Comprehensive ESRD Care – LDO, two-sided track;
- Comprehensive Primary Care Plus (CPC+); and
- Oncology Care Model (two-sided risk track available in 2018).

d. Qualifying APM Thresholds

i. Medicare Option

CMS proposes that QP determinations be made at the Advanced APM entity level. This means that all eligible clinicians participating in the Advanced APM are assessed together and if they meet the thresholds, all will be considered QPs. To determine whether an entity qualifies as a QP, Medicare Part B fee-for-service professional services will be counted, based on Medicare payments (calculated using claims data) or patients "attributed" to the physician (calculated based on the attribution method used in the physician's applicable APM). C MS will use the method that gives the entity the higher score. In both cases, the calculation compares attribution "eligible" beneficiaries (or services performed for these beneficiaries) against beneficiaries actually attributed to the Advanced APM (or services performed for these beneficiaries), and thus beneficiaries who could not be attributed to an Advanced APM are excluded from the calculation. CMS seeks comments on how to apply these calculations when physicians participate in multiple Advanced APMs. The proposed rule outlines the thresholds Advanced APMs must satisfy for their members to become QPs and Partial QPs. Partial QPs are not eligible for Advanced APM bonuses but are also not automatically subject to MIPS. The thresholds increase each year as follows:

Status	Threshold	2019-2020	2021- 2022	2023 & later
QP	Payment	25%	50%	75%
	Patient	20%	35%	50%
Partial QP	Payment	20%	40%	50%
	Patient	10%	25%	35%

Also, CMS provides special treatment for physicians who see patients at CAHs, RHCs, and FQHCs. These services will count as Advanced APM services, as a way to incentivize physicians to see these underserved beneficiaries.

ii. All-Payer Combination Option

In the third year, the Advanced APM can include participation in other-payers' APMs in the threshold calculation. Under the all-payer option, physicians can become QPs with lower levels of participation in Medicare Advanced APMs, if they have sufficient participation in "other payer advanced APMs," *e.g.*, State Medicaid models and commercial payer models (including Medicare Advantage plans), as well as any other payer, other than Medicare fee for service, if the arrangement makes use of CEHRT, uses quality measures comparable to MIPS, and the APM entity bears more than nominal financial risk for health care costs (or for Medicaid models, is a qualifying medical home model).

CMS proposes nominal risk under the all-payer combination option to mean the APM entity is financially responsible for at least 30% of any losses (measured based on actual health care costs exceeding budgeted costs), and total potential risk for the APM entity is equal to at least 4% of total expected expenditures. In addition, capitated risk will qualify (*i.e.*, periodic, per patient payments made in exchange for the provider organization agreeing to provide all necessary care needed for that patient and covered by the capitation payment, with no reconciliation based on actual services rendered).

CMS proposed that non-Medicare APM Entities and/or their affiliated physicians submit information to CMS, by a date and in a manner CMS specifies, so that CMS can determine whether their payment arrangements meet the Other Payer Advanced APM criteria, and if so CMS can calculate the number of patients attributed to the physician through APM entity, and the payment amounts received by the physician(s) from the APM entity.

4. Physician-Focused Payment Models (PFPMs):

MACRA established the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review and recommend PFPMs to CMS for consideration to

test. MACRA also established a process for individuals and stakeholders to propose PFPMs to the PTAC and directed the Secretary to propose criteria that PTAC could use in evaluating PFPMs. The PTAC was considered an additional avenue for specialty physicians to establish APMs that could potentially qualify as an Advanced APM.

Undefined under MACRA, it is left to CMS in the proposed rule to define a PFPM as an "Alternative Payment Model wherein Medicare is a payer, which includes physician group practices or individual physicians as APM Entities and targets the quality and costs of physician services." The PFPM criteria CMS proposes fall into three categories: (1) payment incentives for higher-value care, (2) care delivery, and (3) information availability.

Under the first category, the Secretary proposes assessing PFPMs on the following criteria: (a) value over volume, (b) flexibility, (c) quality and cost, (d) payment methodology, (e) scope, and (f) ability to be evaluated. As to scope, CMS proposes that a PFPM must either address a new issue in payment policy or include a new specialty. The second category seeks to address care delivery improvements by evaluating the PFPM's promotion of better care coordination, protection of patient safety, and encouragement of patient engagement. Finally, CMS proposes a third category aimed at improving the availability of information to guide decision-making, specifically including a criterion that would encourage the use of health information technology to inform care.

CMS also suggests three "supplemental information elements" to include in PFPM proposals, but describes this information as "fundamental" to evaluating new PFPMs:

- Anticipated size and scope of the proposed PFPM, including descriptions and estimates of affected Medicare beneficiaries, expected clinician participants, and anticipated services;
- A description of the burden of disease, illness or disability on the target patient population; and
- An assessment of the financial opportunity for APM Entities, including the benefits to participation as compared to fee-for-service Medicare.

CMS declined to add specialty-specific criteria, and CMS has indicated that it will not prioritize physician specialties, diseases, or patient groups. The proposed rule makes clear that CMS likely does not have the capacity to test all the models recommended by PTAC. And while CMS recommends that a PFPM proposal indicate whether it would meet the criteria for an Advanced APM, the agency is not required to approve PFPMs as Advanced APMs. Moreover, as a practical matter, in light of the 2017 performance year, and the time needed to approve a new model, any models recommended by the PTAC likely

would not begin before the 2019 performance year and 2021 payment year.

5. Program Timeline Summary:

MACRA lays out a complex set of overlapping timelines for the implementation of the MIPS program and participation in Advanced APMs. Below is a reference table summarizing the timeline for each program over the next three years.

Program	2017	2018	2019
MIPS	Reporting and Measurement Period: Performance during 2017 is basis for payment adjustments in 2019. First CMS feedback report provided in July 2017.	Data Submission and CMS Analysis: ECs submit 2017 MIPS data by March 31, 2018. CMS analyzes data.	Payment Year: CMS adjusts PFS payments based on performance in 2017.
Advanced APM	Performance Period: QP status based on participation in Advanced APMs during this period.	Measurement Period: CMS calculates payments for QP services.	Payment Year: CMS makes lump sum incentive payment to QPs.

Depending on the pathway selected by eligible clinicians, Medicare Part B payments will be subject to the Quality Payment Program adjustments summarized in the following table.

Program	2017 – 2018	2019	2020	2021	2022 – 2025	2026
MIPS	None	(+/-) 4%	(+/-) 5%	(+/-) 7%	(+/-) 9%	
Advanced APM	None	+5%	+5%	+5%	+5%	
Baseline PFS Adjustment	+.5%	+.5%	None	None	None	+.25% (MIPS) +.75% (APM)

6. Preliminary Takeaways:

a. Most Providers will Fall Under MIPS In the Early Years of Implementation.

Medicare Part B providers are faced with a relatively short timeline to make any necessary changes in order to qualify for the Advanced APM track. Most models that will qualify for the 2017 performance year have already been awarded and are in process. For those who aren't currently providing services in one of these, it will be difficult to achieve the QP status. Even those clinicians practicing within these models may have difficulty meeting the threshold requirements necessary to trigger the incentive payment and exemption from MIPS reporting. As a result, CMS expects that most eligible clinicians will by default be under MIPS in the first years of implementation. Clinicians and entities should begin planning now if they intend to qualify for QP status under models during future rounds of applications for APM models.

b. Impact on Hospital Acquisition of Physician Practices.

MIPS will streamline the current three quality performance programs into one and provides additional flexibilities to report meaningful measures. Despite this, reporting for MIPS may still be a burden and expense for providers in some circumstances. CMS currently anticipates that smaller practices will be dispro-portionately impacted by the penalties associated with the MIPS program in the earlier years, while larger medical groups will be in position to benefit the most from incentive payments. It is likely that the underlying costs and potential benefits associated with participating in the MIPS program will drive additional consolidation of medical practices and additional practice acquisitions by hospitals.

c. MIPS Includes Some Additional Flexibility.

Despite the administrative and technological challenges associated with participation in the MIPS program, in the proposed rule CMS has responded to feedback from stakeholders and reduced the number of quality measures required. CMS also built in additional flexibility for physicians to select measures relevant to their particular practice and a separate scoring standard for clinicians participating in APMs who do not quality as QPs.

d. Review of Existing Physician Contracts.

Hospitals which employ physicians and/or are parties to professional service contracts with physicians and/or physician groups will need to review existing contracts to determine what changes are necessary. Physician collections from Medicare Part B payments are a key component of these contracts and compensation methodologies may need to be adjusted accordingly.

ABOUT THE FIRM

Founded in 1987, and with clients in all 50 states, Hooper, Lundy & Bookman meets the legal and government relations needs of health care providers across the country. HLB is the largest full service law practice in the country dedicated solely to the representation of health care providers and suppliers. For more information, please visit us at www.health-law.com.

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