McDermott + CONSULTING | HEALTH LOBBYING ANALYTICS POLICY

MACRA: Final Rule Overview

October 31, 2016

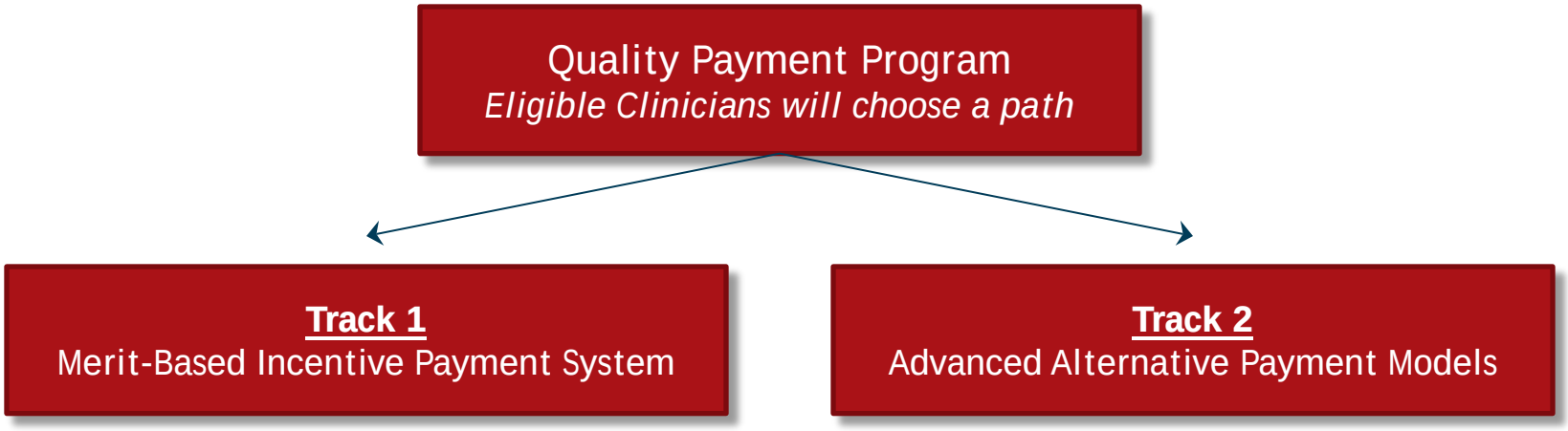
Important Dates

- ✓ Legislation
  - Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 (Public Law 114-10) enacted April 16, 2015
- ✓ Proposed Rule
  - Federal Register publication May 9, 2016
  - Comment period closed June 27, 2016
- ✓ Final Rule
  - Online posted October 14, 2016
  - Federal Register publication November 4, 2016
  - Final Rule comment deadline December 19, 2016
- ✓ Effective Date of Final Rule
  - January 1, 2017

Overview

Beginning in 2019, Eligible Clinicians (including most physicians) will be paid for Medicare Part B services under the new Quality Payment Program (QPP), under which they will select whether to be have payments adjusted under the Merit-based Incentive Payment System (MIPS) or to participate in Advanced Alternative Payment Models (APM).

- Eligible Clinicians choosing the MIPS pathway will have payments increased, maintained or decreased based on relative performance in four categories.
- Eligible Clinicians choosing the APM pathway will receive incentive payments for their participation.



MIPS vs. Advanced APMs

Details	MIPS	Advanced APMs
Payment Adjustment	+/- 4% beginning in 2019; Increases to +/- 9% by 2022 A scaling factor, not to exceed 3X, can be made to positive adjustments to maintain budget neutrality	Not Applicable
Bonus Payments	Providers with aggregated MIPS score in top 25% receive additional positive payment adjustment of up to 10% Available during payment years 2019–24	5% Incentive Payment Available during payment years 2019-24
Annual Fee Schedule Update	0.25% Beginning in 2026	0.75% Beginning in 2026

Final Rule Establishes 2017 as Transition Year

Proposed Rule

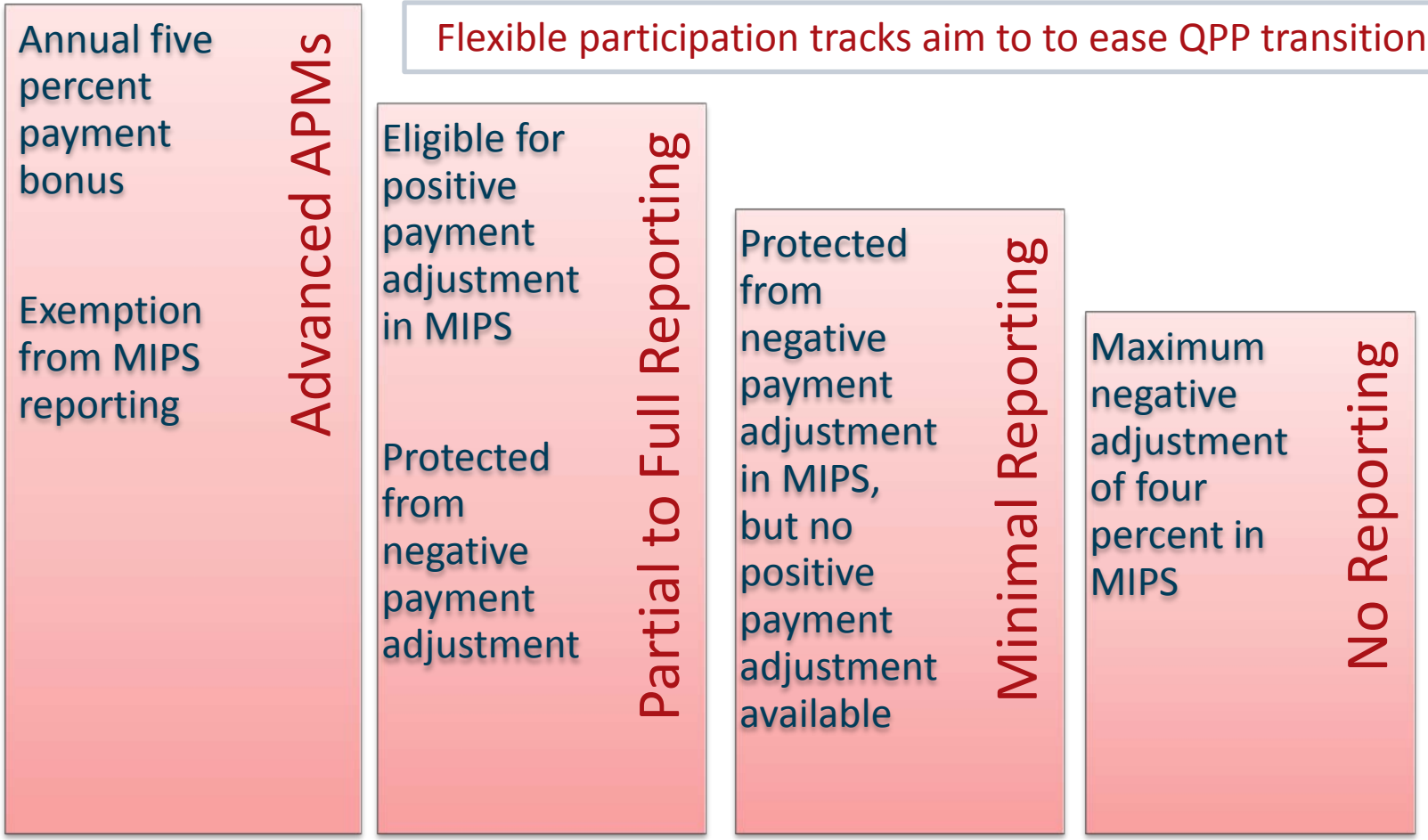
CMS proposed to require full-scale MIPS reporting or APM participation beginning in 2017

CMS finalized policies to ease transition to QPP in 2017

- "Flexible" MIPS participation options offered to ease reporting burden.
- MIPS performance period requirements reduced from full calendar year to 90 days.
- Low volume threshold that exempts certain providers from QPP participation increased from $10,000 to $30,000 in annual Medicare Part B allowed charges.
- Relaxed requirements for Advanced APMs, especially with regard to nominal risk threshold and required EHR use.

CMS Offers New 2017 Participation Options

Flexible participation tracks aim to to ease QPP transition



MIPS/APM Timeline for 2019 Payment Year

Change from Proposed Rule: **Reporting period reduced from 1 year to 90 days.**

2017 Performance Period	2018	2019 Payment Year
• 2017 is the performance period for the 2019 payment year. • MIPS: For 2017, minimum continuous **90-day** reporting required. • Advanced APMs: Must have qualifying participation in 2017 to qualify for a bonus in 2019 payment year.	• MIPS: Data submission deadline is March 31, 2018. • MIPS: Eligible Clinicians will receive performance feedback. • Advanced APMS: Data is submitted by the Advanced APM.	• MIPS: Payment adjustment applied to payments throughout the year. • Advanced APM: Bonuses distributed.

- ✓ In future years, CMS intends to explore ways to shorten the period between the performance period and the payment year.
- ✓ Initially, performance feedback will be provided on an annual basis but CMS will look to provide feedback more frequently in future years.
- ✓ All eligible clinicians will need to report data under MIPS in 2017 even if they expect to qualify for Advanced APM track.

MIPS in Detail

Eligible Clinicians Subject to MIPS

Eligible Clinicians

Physicians, Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, groups that include clinicians who bill under Part B.

CMS estimates that between 592,000 and 642,000 Eligible clinicians will be required to participate in MIPS in 2017.

Physicians and Practitioners Not Subject to MIPS

Any practitioner that does not exceed the low volume threshold of **$30,000** in Part B allowed charges; that has 100 or fewer Medicare patients; is newly enrolled in Medicare; **or** is a Qualified Participant in an Advanced APM.

CMS estimates that in aggregate, the Eligible Clinicians excluded from MIPS represent 22 to 27 percent of total Part B allowed charges.

Change from Proposed Rule
Low volume threshold increased from $10,000 to $30,000.

Beginning in 2021, CMS can require other appropriate providers to participate in QPP.

2017 MIPS Participation Options

No Reporting/ Participation	Minimal Reporting	Partial to Complete Reporting
Eligible Clinicians can choose to not report any data under MIPS in 2017; Medicare payments for non-participants will be reduced 4% in 2017 (maximum penalties will gradually increase to negative 9% adjustments by 2022).	Eligible Clinicians can submit a single measure in the Quality performance category, a single activity in the Clinical Practice Improvement Activity (CPIA) category or the required measures in the Advancing Care Information (ACI) category. Eligible Clinicians who choose this category will not be subject to payment penalties, but also will not be eligible for a positive performance payment adjustment.	Eligible Clinicians who report for a minimum of 90 continuous days within 2017 will be protected from receiving a negative payment adjustment, and will be eligible for a positive payment adjustment. The level of the positive payment adjustments will depend on how much data are submitted and performance results. Upward payment adjustments may be scaled to achieve budget neutrality as required by MACRA.

2017 MIPS Performance Categories

Eligible Clinicians will be measured based on performance in four categories

	Proposed Rule	Final Rule
Quality	• 6 individual measures or 1 measure set with at least one cross-cutting measure and outcome measure (if no outcome measure, one other high priority measure) • Required reporting on 80% of patients (claims method) or 90% (other submission methods)	• 6 quality measures (including outcome measure) or 1 measure set (if no outcome measures are available in the measure set, report another high priority measure) • Requires reporting on 50% of patients (all submission methods)
Advancing Care Information (ACI)	• 11 required measures	• 5 required measures
Clinical Practice Improvement Activities (CPIA)	• 6 medium-weighted activities or • 3 high- weighted activities	• 4 medium-weighted activities OR • 2 high-weighted activities
Cost (previously called Resource Use)	• Continues measures from the Value Modifier program and episode-based measures, as applicable to MIPS eligible clinicians	• Not measured in 2017 performance year

Listed reporting requirements reflect general reporting requirements that apply to most Eligible Clinicians; exceptions for certain circumstances not listed.

MIPS Performance Category Weights

	2019 PY Proposed Rule	2019 PY Final Rule	2020 PY	2021 PY
Quality	50%	60%	50%	30%
ACI*	25%	25%	25%	25%
CPIA	15%	15%	15%	15%
Cost	10%	0%	10%	30%

Change from Proposed Rule: Cost will not be used to determine MIPS final score for 2019.

* The weight for ACI could decrease (not below 15 percent) if CMS estimates that the proportion of physicians who are meaningful EHR users is 75 percent or greater.

- ✓ The Cost performance category will not be used to determine the MIPS final composite score for the 2017 performance period/2019 payment year (PY).
- ✓ Quality performance category weight will be increased for 2019 PY.
- ✓ CMS will calculate performance on certain Cost measures and give this information in performance feedback to Eligible Clinicians for 2019 PY.

Calculating the MIPS Payment Adjustment

MIPS Final Score

Payment adjustment ⇧ if score is above threshold

Annual Threshold

Payment adjustment ⇩ if score is below threshold

2017 Scoring Methodology

- Range of MIPS scores: 0-100
- 2017 Threshold: 3

Score	Description
Below 3	**Negative payment adjustment** • Submit no data.
3	**Avoid negative payment adjustment** • Minimal reporting; *e.g.* a single measure in the Quality performance category, a single activity in the CPIA category or the required measures in the ACI category.
Above 3	**Positive Payment Adjustment** • Partial to complete reporting. • The level of the positive payment adjustment will be based on how much data is submitted and Quality performance results. • Clinicians who achieve a final score of 70 or higher will be eligible for the exceptional performance adjustment, funded from a pool of $500 million. • Upward MIPS payment adjustments may be scaled for budget neutrality, as required by MACRA.

Change from Proposed Rule

CMS is ***not*** finalizing the MIPS scoring proposal to set the performance threshold at a median level where half of the clinicians' scores would be below the performance threshold (and thereby receive a negative payment adjustment) and half would be above the performance threshold (and thereby receive a positive payment adjustment).

Hospital-Based or Non-Patient Facing Participants

Final Rule accommodates unique circumstances of defined providers

Hospital-Based	• MIPS eligible clinician who furnishes 75 percent or more of covered professional services in an inpatient hospital, on-campus outpatient hospital or emergency room setting in the year preceding the performance period.
Non-Patient Facing	• Individual MIPS eligible clinician who bills 100 or fewer patient-facing encounters (including Medicare telehealth services) during the non-patient facing determination period. • A group where more than 75% of the NPIs billing under the group's TIN meet the definition of a non-patient facing individual MIPS eligible clinician during the non-patient facing determination period.

Change from Proposed Rule: The threshold to determine hospital-based MIPS eligible clinicians lowered from 90 percent to 75 percent. On-campus outpatient hospital was added as a site of service.

Change from Proposed Rule: The threshold to determine non-patient facing status increased from 25 to 100 encounters. Revision to the methodology of identifying a non-patient facing group finalized.

Additional Accommodations

Hospital-Based and Non-Patient Facing participants may be exempt from ACI in some circumstances ACI weight percentage will be allocated (reweighted) to the Quality performance category.

	Quality	ACI	CPIA
General Requirements	6 individual measures or 1 measure set with at least one cross-cutting measure and outcome measure (if no outcome measure, one other high priority measure)	5 required measures	4 medium-weighted or 2 high-weighted
Non-Patient Facing	Same requirements apply	Assigned a weight of 0%	2 medium-weighted or 1 high-weighted
Hospital-Based	Same requirements apply	Assigned a weight of 0%*	4 medium-weighted or 2 high-weighted

* When there are not sufficient measures applicable and available.

Reallocation puts substantial emphasis on Quality performance category

Performance Category	Eligible Clinician Reporting in All Categories 2019 MIPS Payment Year	Eligible Clinicians with No ACI Score 2019 MIPS Payment Year
Quality	60%	85%
Cost	0%	0%
CPIA	15%	15%
ACI	25%	0%

Reporting and Scoring for MIPS APMs

Final Rule outlines MIPS reporting and scoring requirements for Eligible Clinicians participating in certain APMs

- CMS will publish list of models qualifying as 'MIPS APMs" on an annual basis prior to the start date of each performance year.
  - Preliminary list for 2017 includes MSSP, Next Gen ACO, CPC+, OCM, CEC.
  - Available at https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf.

- Eligible Clinicians participating in a MIPS APM may realize certain benefits in MIPS even if model is not an 'Advanced APM', such as:
  - Receiving at least half of the maximum CPIA credit depending on APM model.
  - Ability to use quality reporting in the APM as mechanism for meeting MIPS quality reporting requirements; EP will either receive Quality performance score based on APM reporting or have QP scoring waived depending on type of APM.
  - Cost category weighting remains at zero until changed by future rulemaking.

- To determine whether clinicians meet the requirements for the Advanced APM track, all clinicians must report through MIPS in the first year.

Technical Assistance for Small Practices

- **What**
  - MACRA provides $100 million to fund training and education ($20 million each year for 5 years).
- **Who**
  - Medicare clinicians in individual or small group practices of 15 clinicians or fewer and those working in underserved areas.
- **When**
  - Beginning December 2016.
- **How**
  - Local, experienced organizations will use this funding to help small practices select appropriate quality measures and health IT to support their unique needs, train clinicians about the new improvement activities and assist practices in evaluating their options for joining an Advanced APM.

MIPS-Related Provisions Not Implemented in 2017

Virtual groups

- CMS chose not to allow solo and small practices to band together in “virtual groups” to coordinate MIPS reporting.

Facility measures as a proxy for Quality and Cost

- CMS chose not to allow certain Eligible Clinicians *(e.g.*, hospital-based MIPS eligible clinicians) to use measures from other payment systems (*e.g.,* inpatient hospitals) for the Quality and Cost performance categories.

Cost performance category

- Resource use measures will represent 30% of the performance score beginning in 2021, and will represent up to 10-15% of the performance score in 2019 and 2020.
- Cost performance category will not apply in in the 2017 performance period/2019 PY.

Advanced APMs in Detail

Advanced APM Overview: 2019 and 2020 PY

To qualify for the Advanced APM track for 2019 and 2020 payment years, an APM entity must have sufficient payment or patient volume in Medicare models meeting three specified criteria for Advanced APMs:

1. Meet quality reporting requirements
2. Meet certified electronic health record technology (CEHRT) use requirements
3. Meet nominal risk requirements

Qualifying and Partial Qualifying Participants

- **Qualifying APM Participant**
  - Eligible Clinicians who meet the applicable participation threshold in Advanced Alternative Payment Models are exempt from MIPS reporting requirements and receive financial benefits.
    - 2019-2024: 5 percent annual payment bonus
    - 0.75% annual update beginning in 2026

- **Partial Qualifying APM Participant**
  - Eligible Clinicians who meet a reduced participation threshold are not subject to MIPS reporting but do not qualify for Advanced APM bonus payment.

Participant Threshold: Medicare Only Track

Requirements for Incentive Payments for Significant Participation in Advanced APMs
Clinicians must meet payment or patient thresholds to qualify for Advanced APM incentive payment

MEDICARE ONLY TRACK BEGINS IN PAYMENT YEAR 2019

Status	Threshold	2019–20	2021-22	2023 and Beyond
Qualifying Participant	Payment	25%	50%	75%
	Patient	20%	35%	50%
Partial Qualifying Participant	Payment	20%	40%	50%
	Patient	10%	25%	35%

Participation in multiple APMs
If an individual eligible clinician who participates in multiple Advanced APMs does not achieve QP status through participation in a single Advanced APM, CMS will determine QP status based on combined participation in multiple Advanced APMs.

Participant Threshold: All Payer Combination

Requirements for Incentive Payments for Significant Participation in Advanced APMs
Clinicians must meet payment ***or*** patient requirements for the Medicare ***and*** All Payer Threshold

ALL PAYER COMBINATION TRACK BEGINS IN 2021

Status	Threshold	2019 – 2020	2021 – 2022	2023 & Beyond
Qualifying Participant	***Medicare Threshold***			
	Payment Threshold	N/A	25%	25%
	Patient Threshold	N/A	20%	20%
	All Payer (Total) Threshold			
	Payment Threshold	N/A	50%	75%
	Patient Threshold	N/A	35%	50%
Partial Qualifying Participant	***Medicare Threshold***			
	Payment Threshold	N/A	20%	20%
	Patient Threshold	N/A	10%	10%
	All Payer (Total) Threshold			
	Payment Threshold	N/A	40%	50%
	Patient Threshold	N/A	25%	35%

Data Must Be Submitted to CMS

For the All Payer Combination option, the APM or the eligible clinicians are required to submit to CMS financial data, an attestation on the accuracy of the financial data, an outcome measure if available, or an attestation there is no applicable outcome measure on the MIPS list of quality measures.

Timeline and Participation Categories

Timeline

2019

- All providers participate in MIPS in the first year
- APM Option 1: Medicare Only

2020

- APM Option 1: Medicare Only

2021 & Beyond

- APM Option 1: Medicare Only
- APM Option 2: All Payer Combination (Medicare, Private Payer and Medicaid)

Participation Categories

An Advanced APM Entity would provide a list of eligible clinicians associated with its APM to CMS; CMS proposes to make the Qualifying Participant determination at the group level (with some exceptions), which would apply to all individual eligible clinicians in the group.

Qualifying APM Participant	Partial Qualifying APM Participant	Intermediate Option
▪ Meets **higher threshold** based on payments received through an APM or patient percentage (varies by year) ▪ **Eligible** for APM bonuses and annual updates ▪ **Not subject** to MIPS	▪ Meets **lower threshold** based on payments received through an APM or patient percentage (varies by year) ▪ **Not eligible** for APM bonuses and annual updates ▪ **Not subject** to MIPS	▪ Participates in APMs but does not meet QP or Partial QP thresholds ▪ NOT eligible for APM bonuses and annual updates ▪ Subject to MIPS ▪ CMS established a scoring standard for MIPS eligible clinicians participating in certain types of APMs to reduce the reporting burden

2017 Advanced APM Options

CMS will publish the final list of 2017 Advance APM options before January 1, 2017; the following models are expected to qualify as Advanced APMs:

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

Change from Proposed Rule: CMS is considering a new MSSP Track 1+ model for 2018.

CMS estimates that 70,000 to 120,000 clinicians will participate in Advanced APMs and qualify for the 5% incentive payment in 2017.

* LDO = large dialysis organization; non-LDO = non-large dialysis organization

2018 Advanced APM Options

For the 2018 performance year, CMS anticipates that the following models will be Advanced APMs (in addition to the 2017 list):

Physician-Focused Technical Advisory Committee (PTAC)

- MACRA established the PTAC to review and assess Physician-Focused Payment Models based on proposals submitted by stakeholders to the committee.
- CMS finalized the criteria for the committee to use in reviewing these proposals: Proposed Physician-focused Payment Models should reduce cost, improve care, or both.

CMS Finalizes EHR & Quality Requirements

EHR	Quality
CMS slows timeline for increasing percentage of Eligible Clinicians Using Certified EHR Technology (CEHRT) • Requires 50 percent of the eligible clinicians within an APM entity or group to use CEHRT in both 2017 and 2018. • Eliminates proposed requirement to increase participation to 75 percent in CY 2018.	**CMS Finalizes Quality Measurement Requirements Including Outcome Measure** • Payment must be based on reporting on quality measures that are evidenced-based, reliable and valid (examples include measures that are used in the MIPS performance category, endorsed by a consensus-based entity, or are submitted in response to the MIPS Call for Quality Measures). • Requires at least one reported outcome measure unless CMS determines that no such measure is available in the appropriate area of practice. • Indicates intent to establish an internal Innovation Center that is tasked with reviewing measures that are not NQF-endorsed or on the final MIPS measure list to determine whether measures meet the Advanced APM track criteria.

Nominal Risk Requirements Relaxed

FINAL POLICY: For the 2019 and 2020 payment years, an Advanced APM will meet the nominal risk standard if an entity would be required to repay or forego at least: 8 percent of the average estimated total Medicare Parts A and B revenue for the entity; or 3 percent of the expected expenditures for which the entity is responsible under the APM.

Proposed Rule	Final Rule
• Proposed assessing three dimensions of risk in its evaluation of a model's- marginal risk, minimal loss ratio (MLR) and total potential risk. • Required a model to include marginal risk of least 30 percent of losses in excess of the benchmark amount as well as a MLR of no greater than four percent and a total risk amount of at least four percent.	• Requires only the total risk measure for 2019 PY; eliminates marginal risk and minimal loss ratio for first payment year. • Reduces the total risk threshold from a minimum of four percent to three percent for 2019 and 2020 PYs. • Introduces a second "revenue-based" option for assessing total risk if APM entity has more than 8 percent of its average estimated Medicare Parts A and B revenue at risk in model.

Other Models

Medicare Medical Home Standard Finalized, Including 50 EP Size Limit Beginning in 2018

- APM entity must be at risk to either repay or forego a minimum amount equal to 2.5 percent of the APM entity's total Medicare Parts A and B revenue in 2017, 3 percent in 2018, 4 percent in 2019 and 5 percent in 2020 and beyond.
- APM entities that can count medical home model participation in the APM track are limited to organizations with fewer than 50 eligible clinicians (including the employees of the parent organization in addition to the APM entity itself).
- All APM entities could be able to qualify under the medical home option regardless of size in 2017.

Full Capitation Models Count As Advanced APMs; Medicare Advantage Plan Models Do Not Qualify for 2019 and 2020 Payment Year

- APMs that include a full capitation risk arrangement can qualify as Advanced APMs; partial capitation models will be evaluated on an individual basis based upon the nominal risk criteria.
- Payments made under the Medicare Advantage program cannot count towards the Medicare-only threshold amount in 2017 and 2018; individual assessment of contract between MA plan and providers will be used to determine if MA payments meet the Advanced APM criteria models under the all payer combination model.

MACRA-related Resources

CMS has established resources to assist with MACRA implementation

- Quality Payment Program website: Website explains the new program and help clinicians identify relevant measures and clinical improvement activities.
  - https://qpp.cms.gov/
- Transforming Clinical Practice Initiative: Established by the Affordable Care Act to assist clinicians with health care transformation.
  - https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/
- Quality Innovation Network (QIN)-Quality Improvement Organizations (QIO): The QIO Program's 14 QIN-QIOs bring together Medicare beneficiaries, providers, and communities.
  - http://qioprogram.org/contact-zones?map=qin
- APM Learning Systems: Specialized information for Advanced APM participants.
  - More information available through model's inbox.

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