

Friday, October 14, 2016

CMS FINALIZES KEY PROVISIONS OF MACRA PHYSICIAN PAYMENT SYSTEM FOR 2019

The Centers for Medicare & Medicaid Services (CMS) this morning issued a final [rule](#) with comment period implementing key provisions of the new physician payment system required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The law repeals the flawed Medicare sustainable growth rate methodology for updates to the physician fee schedule and requires CMS to establish a new physician quality and value-based payment program – the [Quality Payment Program](#) (QPP) – that starts in calendar year (CY) 2019. Eligible clinicians will participate in one of two tracks – the default Merit-based Incentive Payment System (MIPS) or alternative payment models (APMs) – and their 2019 payments will be tied to performance during 2017.

The rule finalizes most of the key policies for the 2019 QPP. The rule also finalizes policies related to blocking of health information and electronic health record (EHR) surveillance that apply to all hospitals, critical access hospitals and physicians. Finally, CMS requests comments on certain new or modified proposals. Select highlights of the final rule follow.

AHA View: We are [disappointed](#) that CMS continues to narrowly define advanced APMs, which means that less than 10 percent of clinicians will be rewarded for their care transformation efforts. However, we are encouraged that CMS is exploring a new option that would expand the available advanced APMs that qualify for incentives. In addition, we are pleased that CMS has provided clinicians with increased flexibility to meet MACRA’s aggressive timelines and reporting requirements by allowing them to “pick their pace.”

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Overview of the MIPS. Starting in 2019, the MIPS will be the default payment system for eligible clinicians, which includes physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists. Clinicians will be permitted to participate as either individual clinicians or as group practices. The MIPS assesses eligible clinicians on four performance categories – quality measures, cost measures, clinical practice improvement activities (CPIAs) and advancing care information (ACI). Based on their MIPS performance, eligible clinicians

will receive positive or negative payment adjustments of 4 percent in CY 2019, rising gradually to a maximum of 9 percent in CY 2022 and beyond.

MIPS Flexibility for Year 1. CMS proposed to require clinicians to collect and report a full year of data for all MIPS categories from CY 2017 for CY 2019 MIPS payment adjustments. However, the AHA and numerous other stakeholders expressed significant concern about the readiness of the field to meet this aggressive requirement. As a result, in September, CMS signaled its [intention](#) to provide greater flexibility in meeting MIPS timelines. The final rule adopts two policy key policy changes intended to allow clinicians to avoid payment penalties and “pick their pace” of MIPS participation.

First, CMS shortens the performance period for CY 2019 MIPS payment adjustment. Clinicians will be required to report data for a period of any 90 continuous days during CY 2017. Clinicians may choose to report more than 90 days of data, but are not required to do so. CMS suggests it intends to require longer reporting periods in future program years.

Second, CMS offers additional flexibility by providing clinicians with three options for MIPS participation during CY 2017:

- **Report “some” data to avoid a penalty, but receive no incentive payments.** Specifically, clinicians that report any of the following will avoid a penalty:
 - At least one measure in the quality category;
 - One CPIA; or
 - The measures required under the ACI category.
- **Report data MIPS categories for a continuous 90 days to avoid a penalty and be potentially eligible for small positive MIPS adjustments.** Specifically, clinicians will be expected to report:
 - More than one measure in the quality category;
 - More than one CPIA; or
 - More than the measures required in the ACI category.
- **Report all required data in all MIPS categories for at least 90 continuous days, and be eligible for larger positive MIPS incentives.** Additional details on the finalized reporting requirements for each category are provided later in this bulletin.

Low-volume Threshold. The MACRA requires CMS to exempt several categories of clinicians from the MIPS, including clinicians who fall below a low-volume threshold during the performance period. In response to concerns raised by the AHA and other stakeholders about the readiness of small and rural practices to meet MIPS requirements, CMS finalizes an increase to the low-volume threshold. Clinicians billing \$30,000 or less of Medicare charges, or that see 100 or fewer Medicare patients, will **not** be required to participate in the MIPS.

Performance Categories. CMS adopts the measures, activities and data submission standards for each of the MIPS categories. In addition, CMS finalizes the weights it will

assign to each category in determining a Composite Performance Score (CPS). The CPS will be used in determining payment adjustments. **Notably, in response to stakeholder concerns, CMS will not score clinicians on the cost category for CY 2019 payment adjustments, and will raise the weight of the quality measure category by 10 percent.**

CMS's final policies, and the weights for each category for CY 2019, are briefly summarized below. Fulfilling the requirements below is required to qualify for incentive payments, but as noted in the section above on MIPS Year 1 flexibility, clinicians that report less data can still avoid a payment penalty.

- Quality (60 percent of CPS). In general, CMS will require clinicians and groups to report at least six measures. Among the six measures, CMS will require the reporting of at least one outcome measure. Alternatively, clinicians can choose to report all of the measures from a particular specialty measure set, even if that set includes fewer than six measures.
- Clinical Practice Improvement Activities (15 percent of CPS). The MACRA requires that CMS establish a MIPS performance category that rewards participation in activities that improve clinical practice, such as care coordination, beneficiary engagement and patient safety. CMS adopts a list of over 90 activities from which clinicians can select to fulfill this category. Each activity is assigned a weight towards the overall score. As required by the MACRA, clinicians participating in certified patient-centered medical homes will automatically receive the highest score. However, for other CPIAs, clinicians generally will need to participate in more than one activity to receive the highest score.
- Advancing Care Information (25 percent of CPS). CMS finalized several changes in the ACI category. Specifically, eligible clinicians must report five measures for four objectives, a reduction from the proposal to report on 11 measures for six objectives. CMS increased the number of measures available to earn performance score credit by including the four measures in the Public Health and Clinical Data Registry objective. CMS also will award bonus points under the ACI category for clinicians that use certified EHRs to complete certain activities within the CPIA category.

INCENTIVES FOR PARTICIPANTS IN ALTERNATIVE PAYMENT MODELS (APMs)

The MACRA provides incentives for clinicians who participate in advanced APMs. These include a bonus payment of 5 percent of payments for professional services in 2019 through 2024; exemption from MIPS reporting requirements and potential payment cuts; and higher base payment updates beginning in 2026. In this rule, CMS finalizes the criteria by which physicians and other professionals will qualify for these incentives.

Identification of Medicare Advanced APMs. The MACRA specifies that only models that meet certain requirements qualify as advanced APMs for purposes of the

incentives. Specifically, the law mandates that the model require participants to use certified EHR technology and to tie clinician payment to performance on quality measures comparable to those in the MIPS quality category. In addition, the model must require that entities participating in the APM (known as APM entities) bear risk for monetary losses of more than a nominal amount, or be a medical home model expanded under Center for Medicare and Medicaid Innovation authority.

Use of Certified EHR Technology. CMS finalized its proposal requiring that participants in the advanced APM models use technology that meets the current definitions of certified EHR technology. In addition, an advanced APM must require at least 50 percent of eligible clinicians who are enrolled in Medicare (or each hospital, if the hospital is the APM participant) to use the certified health IT functions to document and communicate clinical care with patients and other health care professionals.

Quality Measurement. Recognizing that different measures may be appropriate for different payment models, CMS finalized its proposal to adopt a flexible approach. Specifically, the quality measures tied to payment in an advanced APM must include at least one of the following types of measures, provided the measures have an evidence-based focus and are reliable and valid:

- Any of the quality measures included on the proposed annual list of MIPS quality measures;
- Quality measures that are endorsed by a consensus-based entity;
- Quality measures developed under CMS’s authority to develop new measures;
- Quality measures submitted in response to the MIPS call for quality measures; and
- Any other measures that CMS determines to have an evidence-based focus and be reliable and valid.

Financial Risk for Monetary Loss. CMS finalized its proposal to create two standards for financial risk for monetary loss – one that applies generally to entities participating in advanced APMs, and another that applies to medical home models.

The generally applicable financial risk standard finalized by CMS requires that an APM entity incur some of the financial loss when “actual expenditures [such as through a benchmark or target price] exceed projected expenditures.” The loss can occur through withheld payments for services, reduced payment rates or required repayment to CMS. **The AHA is disappointed that CMS finalized this approach, which does not acknowledge the significant investment that providers make to participate in these models.**

For medical home models, CMS finalized its proposal that the model satisfies the financial risk standard if it includes provisions that potentially withhold payment for services; reduces payment rates; requires repayment to CMS; or eliminates the right to all or part of an otherwise guaranteed payment(s) if either actual expenditures for which the entity is responsible exceed expected expenditures, or the entity’s performance on specified performance measures does not meet or exceed expected performance. CMS also finalized its proposal to limit the medical home model financial risk standard to

APM entities owned and operated by organizations with 50 or fewer clinicians, beginning in 2018.

The agency also specified that full capitation risk arrangements meet the financial risk criterion. However, CMS notes that Medicare Advantage is not a Medicare advanced APM.

Nominal Amount of Monetary Loss. CMS finalized with changes the amount of risk an entity must accept for a model to qualify as an advanced APM. Specifically, an APM entity that demonstrates annual losses must potentially owe a total amount equal to either:

- 8 percent of the average estimated total Medicare Parts A and B revenues of the APM entity (the “revenue standard”), or
- 3 percent of the expected expenditures (i.e., the benchmark or target price set under the model) for which the APM entity is responsible (the “benchmark-based standard”).

The revenue standard option only is available for performance years 2017 and 2018, while the benchmark-based standard is applicable for all performance years.

For medical home models, CMS finalized its proposal that the total amount that an APM entity potentially forgoes or owes CMS must be at least the following percent of the entity’s total Medicare Parts A and B revenue:

- 2017 – 2.5 percent
- 2018 – 3 percent
- 2019 – 4 percent
- 2020 and beyond – 5 percent

Application of Criteria to Current APMs. Applying these criteria to current APMs, the only models that qualify as advanced APMs are Medicare Shared Savings Program (MSSP) Tracks 2 and 3, the Next Generation ACO model, the Comprehensive End-stage Renal Disease Care model, and the two-sided risk model in the Oncology Care program. The newly announced, but not yet implemented, Comprehensive Primary Care Plus initiative will qualify as a medical home. In addition, in separate rulemaking, CMS has [proposed](#) to create a track under which the Comprehensive Care for Joint Replacement model would qualify as an advanced APM. The agency’s newly [proposed](#) bundled payment programs for both surgical treatment for hip and femur fracture and cardiac procedures would also have tracks under which they could qualify as advanced APMs.

In addition, CMS states that it will explore a new ACO option that would expand the number of available advanced APMs. Specifically, it is considering testing a “Medicare ACO Track 1+ Model” starting for the 2018 performance year. The Track 1+ Model would test the use of more limited downside risk than is currently present in Tracks 2 or 3 of the MSSP in order to encourage more rapid progression to performance-based risk. The agency states that it will announce additional information about the Track 1+ Model

in the future. **We are pleased that CMS is considering this option and look forward to working with them to ensure that it strikes an appropriate balance between risk and reward, but believe that the option should be available in the 2017 performance year.**

INFORMATION BLOCKING AND EHR SURVEILLANCE

Information Blocking. CMS finalized as proposed requirements that hospitals, critical access hospitals, physicians and other eligible clinicians attest to three separate statements indicating that they did not “knowingly and willfully take action to limit or restrict the compatibility or interoperability” of their certified EHR, that they have implemented the technology to support “secure and trusted bi-directional exchange” of health information, and have “responded in good faith and in a timely manner” to requests for exchange information from others.

The AHA remains concerned that current technology and information sharing infrastructure do not support the level of exchange contemplated by the attestation statements.

EHR Surveillance. The Office of the National Coordinator for Health Information Technology recently finalized a rule to enhanced oversight of certified health IT and increase transparency of the surveillance results. CMS finalized a modified requirement that hospitals, critical access hospitals and clinicians attest that they acknowledge the requirement to cooperate in good faith with ONC if that agency is engaged in a direct review of health information technology that they use

NEXT STEPS

Comments on specific aspects of the final rule will be accepted through 60 days after publication in the Federal Register. For example, CMS is soliciting comment on its modifications to how “topped out” measures are scored. Provisions in the rule generally are effective Jan. 1, 2017. Watch for a more detailed AHA analysis of the final rule in the coming weeks. Additional resources on the new physician payment system can be found at www.aha.org/MACRA.

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