MACRA QUALITY PAYMENT PROGRAM PROPOSED RULE

SUMMARY

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On April 27, the Centers for Medicare & Medicaid Services (CMS) released the proposed rule to implement the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Background

The Proposed Rule includes program-specific details on how CMS intends improve physician payments by changing the way Medicare incorporates quality measurement into payments and by developing new policies to address and incentivize participation in APMs.

MACRA permanently repealed the Sustainable Growth Rate (SGR) formula for calculating physician payments and, in its place, implemented two performance-based paths:

1. Continue to participate under the Medicare Physician Fee Schedule and receive a bonus or penalty associated with the eligible clinician's MIPS performance; or
2. Earn separate incentive payments through participation in an advanced APM and be excluded from participating in MIPS.
    - *Only a very small number of LTPAC medical providers currently participate in an Advanced APM – most LTC providers should plan on having to satisfy MIPS reporting requirements to avoid payment penalties.*

When do changes take effect?

Services provided beginning on Jan. 1, 2017, will directly impact reimbursement provided in 2019, the first year in which the MIPS program and APMs are effective.

Proposed Timeline

- 2017 – Performance period begins; data must be collected for a full year.
- 2018 – Reporting and CMS data analysis
- 2019 – MIPS adjustments in effect

Clinicians will receive positive, negative, or neutral adjustments to the Medicare Physician Fee Schedule beginning in 2019. The proposed, budget neutral, adjustments are:

- 2019 +/- 4%
- 2020 +/- 5%
- 2021 +/- 7%
- 2022 +/- 9%

MIPS Combines Four Existing CMS Payment Modification Initiatives Under a Single Banner

- ACI (advancing care improvement) – replaces Meaningful Use for Medicare Part B. LTPAC medical groups electing to continue demonstrating Medicaid Meaningful Use are *probably* going to have to report under both MIPS and Medicaid MU.
- Quality – combines PQRS reporting and VBP's Quality Scoring into a single measurement scheme.
- Clinical Practice Improvement Activities – replaces the optional Maintenance of Certification (MOC) program which was to intended to reward providers who undertook specified annual educational or practice improvement activities (similar to QAPI for Nursing Homes)
- Resource Use – Replaces the Cost measurement section of VBP.

Overview of Proposed Changes – LTC Impact

GPM is still reviewing the details of the 962-page rule, but of note for LTC providers include the following proposed provisions:

- 'Eligible provider' is now referred to as 'Eligible Clinician': MD/DO, DMD/DDS, PA, NP, Clinical Nurse specialist, certified nurse anesthetist (CMS intends to specify additional eligible clinicians in future rulemaking);
- Services billed under CPT codes 99304-99318 are excluded from the definition of primary care services for MIPS under the Resource Use Criteria category when the claim includes the POS 31 (SNF, meaning a resident receiving skilled post-acute services) modifier.
    - This means your average patient cost should be lower because none of the patients your practice saw *exclusively* in the SNF setting are 'attributed' to your group. For all other MIPS calculations these individuals are included in your performance measurement.
- MIPS-eligible clinicians who lack control over the EHR technology in their practice locations would need to submit an application demonstrating that a majority, 50 percent or more, of their

outpatient encounters occur in locations where they have no control over the health IT decision of the facility, and request their Advancing Care Information performance category score be reweighted to zero;

This mirrors the existing Medicare EHR Meaningful Use Hardship Exemption most LTPAC Physicians exercised in 2014-16. Exercising that exemption made sense under MU, which was an 'all or none' program. The MIPS ACI component is an incremental measure with 6 equally weighted parts – some of which only require 'attestation' and the use of a Certified EHR (e.g. gEHRiMed™.

- The MIPS quality category requires providers to report 6 individual measures, fewer than are currently required under the Physician Quality Reporting System (PQRS). *Measures Groups* are not a part of MIPS. Partial credit is available and bonus points are available for reporting high priority measures and electronically reporting quality data;
- The MIPS cost category measures come from claims data, allowing CMS to calculate performance independently;
- The EHR use category—now known as "Advancing Care Information"—moves away from an all-or-nothing approach, and promises more customizable measures; and
- CMS defines two approaches to meeting the advanced alternative payment models (APMs) threshold—based on either revenue at risk or number of patients attributed under risk.
- Track 1 ACO's and BPCI are not considered Advanced APMs';
- All providers will report through MIPS in 2017 and will be assessed for achievement of Advanced APM requirements and eligibility for QP bonuses.
- Providers who bill less than $10,000 AND provide care for 100 or fewer Part B-enrolled Medicare beneficiaries are exempt from MIPS, so new hires to your TIN who don't meet threshold will not have to report, different from the PQRS program.
- Partial year data is acceptable
- MIPS eligible clinicians and groups may elect to submit information for MIPS via multiple mechanisms; however, they may only use one submission mechanism per category.

OVERVIEW OF NPRM:

Who is Has to Participate in MIPS?

Affected healthcare professionals are called MIPS "eligible clinicians." The types of Medicare Part B eligible clinicians in the first two years of implementation will be:

- physicians (MD/DO and DMD/DDS)
- physician assistants
- nurse practitioners
- certified nurse specialists
- certified registered nurse anesthetists

In the future, MIPS may be extended to include physician therapists and occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, and dieticians/nutritional professionals.

Exemptions

Excluded from MIPS are:

- first-year Medicare Part B participants,
- low patient volume providers (who bill less than or equal to $10,000 AND provide care for 100 or fewer Medicare patients in one year), and
- certain participants in Advanced APMs.

MIPS does not apply to hospitals or facilities.

MIPS eligible clinicians who bill for services under Medicare Part B PFS for their patient care in nursing facilities are eligible for MIPS.

MERIT-BASED INCENTIVE PAYMENT SYSTEM OVERVIEW

MIPS rewards physicians who provide high-quality, low-cost care based on four areas of evaluation: quality care (formerly PQRS), cost-of-care/resource use (formerly VBPM), advancing care information program (formerly MU), and the new clinical practice improvement activities. The four categories are weighted and combined into an overall composite performance score (CPS) from 0-100. Scores below 25 will receive the maximum negative adjustment (i.e. <4%> In year 1). All other scores will be compared with a performance threshold based on the performance of all eligible MIPS providers to determine the amount of negative or positive adjustment to physicians' fees. The thresholds will be published annually, in advance of the performance period to be measured, so clinicians will know what

composite score will be needed to receive incentive payments or avoid penalties at the beginning of each performance year. The weights of these categories may be adjusted if there are not sufficient measures and activities applicable for each type of EP, including assigning a scoring weight of 0 for a performance category (for instance, the advancing care information category is optional for non-physician providers in 2017 and the weight of the ACI category will be redistributed in this instance). MIPS eligible clinicians may submit data to CMS in a variety of ways but a single submission mechanism will be used for each category. QCDRs (Quality Clinical Data Registries, like GPM) are able to submit data for all four performance categories. Payment adjustments will take place two years after the performance period.

MIPS CATEGORIES, WEIGHTS, AND REPORTING DETAILS

Categories	Replaces	2019 Weighting	2020 Weighting	2021+ Weighting	Reporting Details
Quality	PQRS	50%	45%	30%	6 measures (includes 1 cross-cutting measure and one outcome measure (or high priority measure). Bonus points available up to 5% of the total quality score.
Advancing Care Information	Meaningful Use	25%	25%	25%	50% credit for attesting yes to 6 base measures. 50% of score based on performance on 11 measures
Clinical practice improvement activities	Maintenance of Certification	15%	15%	15%	60 points by activities worth either 20 points or 10 points from 90+ choices in 9 categories.
Cost / Resource use	VBPM	10%	15%	30%	Average score of all cost measures that can be attributed taken from Medicare claims (total per capita costs for all attributed beneficiaries and Medicare spending per beneficiary plus

					several new cost measures from 41 episode-specific measures.
Total Composite Performance Score		100%	100%	100%	0-100 score is then benchmarked against ambulatory peers' performance threshold to determine your Medicare PFS adjustment.

How You Can Participate

- As an individual
- As a group – all providers in the group (TIN) will be assessed together for all 4 categories for the full calendar year. Consideration of partial year performance will not be necessary for assessment of groups, which should have adequate coverage across MIPS eligible clinicians to provide valid performance calculations.
- As a MIPS APM Entity group (with MIPS incentives for APM participation that doesn't meet criteria to be excluded from MIPS)
- As a virtual group beginning in 2018 (can apply to join with at least one other TIN of similar size of 10 or fewer eligible professionals)

Quality Performance

Eligible clinicians will select and report on six individual Quality Measures, rather than nine individual measures, or a Measures Group. An additional 2-3 QMs (depending on the practice size) are calculated from claims. Measures groups are no longer available under MIPS. Each measure reported will count for 1-10 points based on how a MIPS eligible clinician's performance compares to benchmark (if available). The six measures reported and those calculated from claims are averaged to score this category (80-90 total points depending on group size). The quality category is weighted 50% of the entire MIPS Composite Performance Score in 2017.

Eligible clinicians may select 6 individual measures from:

1) a list of over 300 individual measures or

2) from a specialty specific measure sets (NPRM Appendix Table E)

Minimum Patient Reporting thresholds for the quality category have significantly increased under MIPS.

- If reporting via claims, clinicians must report on 80% of their Medicare Part B patients.
- If reporting through the EHR, registry, or QCDR, 90% of patients (all payer -Medicare AND Non-Medicare Patient Data) must have quality measures scored. QCDR, qualified registry, or EHR submissions must contain a minimum of one quality measure for at least one Medicare patient.
- Additionally, each quality measure must have a minimum number of 20 patients for each measure reported to contribute to the quality score.
- If there is an insufficient sample size for a reported measure or a measure lacks a benchmark, the clinician would not be penalized with a score of 0 for the measure, the measures just would not contribute to the quality score (remaining measures will be averaged together for the quality category).

Eligible clinicians must report on one cross-cutting measure (NPRM Appendix Table C) and one outcome measure, if available (labeled in NPRM Appendix Table A). Bonus points are available for an outcomes measure (2 points).

If an outcome measure is not available, a physician may select a "high priority" measure (e.g., appropriate use, patient safety, efficiency, patient experience or care coordination measures). While reporting a certain number of NQS measure domains is no longer a part of quality reporting under MIPS, bonus points are available for measures determined to be high priority. When two or more high priority measures are reported (the outcome measure will count as the first of two high priority measures but won't receive any bonus points when in the required measure spot). Bonuses in the quality category from high priority measures cannot exceed 5% of the total quality score but include:

- Patient experience measures (2 bonus points)
- Appropriate use, patient safety, efficiency and care coordination measures (1 bonus point)

"For example, if a MIPS eligible clinician submitted two outcome measures, and two patient safety measures, the MIPS eligible clinician would receive two bonus points for the second outcome measure reported and two bonus points for the two patient safety measures. The MIPS eligible clinician would

not receive any bonus points for the first outcome measure submitted since that is a required measure." P. 314.

Claims-based measures will also be calculated for the quality category

CMS proposes to add 2-3 administrative claims-based population health measures (NPRM Appendix Table B) to the quality category that were previously part of the VBM, depending on practice size (the acute and chronic composite measures of AHRQ Prevention Quality Indicators (PQIs) and the all-cause hospital readmissions measure that was part of the old Value Modifier formula (groups of less than 10 will not be evaluated on the all cause readmission measure due to their small size). Note CMS intends to risk adjust the acute and chronic composite measures as soon as feasible and that the all-cause hospital readmission measure has a minimum of 200 cases.

How the quality category will be scored?

The quality category's performance is calculated by summing the weighted points assigned for the required measures, plus any bonus points, and dividing by the weighted sum of the total possible points. Eligible clinicians only receive bonus points if the performance rate is greater than zero. If there are more bonus points scored than allowed under the high priority measure cap AND the electronic reporting cap, the maximum bonus points for each category (up to 5% of the 80 possible points or 4 points per bonus category) will be added to the quality points to determine the quality score. If the quality score exceeds 50%, since the quality category only counts for 50% of the MIPS CPS, the quality score will be 50%. If a MIPS eligible clinician elects to report more than the minimum number of measures to meet the MIPS quality performance category criteria, then only the scores for the measures with the highest number of assigned points will be include in the quality category score.

Since Quality is the single largest component of the MIPS program, selecting measures where the individual or group will achieve high scores is a key strategy. GPM will continue with a QM strategy similar to what was offered for PQRS – identifying LTPAC appropriate measures and tracking their use against required reporting thresholds. Overall, Quality will require more effort than reporting a single Measures Group to satisfy PQRS.

MIPS clinicians who do not report the required cross-cutting or outcome measures (or alternate measures in "high priority" areas) will be at a disadvantage under the proposed quality performance scoring methodology receiving a 0 for the missing measures.

ECs or groups who report on all required measures and activities could potentially obtain the highest score possible within the performance category, presuming they perform well on the measures and activities they report. An EC or group who does not meet the reporting threshold would receive a zero score for the unreported items in the category but will receive partial credit for reporting less than 6 measures. The MIPS eligible clinician or group could still obtain a relatively good score by performing very well on the remaining items, but a zero score would prevent the MIPS eligible clinician or group from obtaining the highest possible score. CMS intends to develop a validation process to review and validate a MIPS eligible clinician's inability to report on the quality performance requirements.

The quality data for the six measures must be captured for the full reporting period (January 1, 2017-December 31, 2017.) Those providers who do not have data for the full year due to leave, illness or switching practices will be required to report all performance data available.

In the first year of MIPS, the majority of the quality measures will be previously implemented PQRS measures (NPRM Appendix Table A). Benchmarks for the quality performance category in 2017 will be based on 2015 performance, with the exception of new measures for which benchmarks will be set using performance in the performance period (different from the VM program where new measures didn't contribute to your score). The GRPO WI will use the 2017 benchmarks from the MSSP program (and assign all scores below the 30th percentile a value of 2 points). Any MIPS eligible clinician who reports some level of performance will receive a minimum of one point for reporting if the measure has the required case minimum, assuming the measure has a benchmark. Note that *topped out* measures will not be removed for 2017 but will be treated differently in their point assignments to discourage their use in reporting.

GPM will identify 'topped out' measures for user, and suggest alternatives if available.

Quality measures that are owned or developed by a QCDR entity and proposed by the QCDR for inclusion in MIPS but are not a part of the MIPS quality measure set are considered non-MIPS measures. If a QCDR wants to use a non-MIPS measure for inclusion in the MIPS program for reporting, it is proposed that these measures go through a rigorous CMS approval process during the QCDR self-nomination period. Once the measures are analyzed, the QCDR will be notified of which measures are approved for implementation. Each non-MIPS measure will be assigned a unique ID that can only be used by the QCDR that proposed it.

In future years, it may become reasonable for LTPAC medical groups to agree on a population specific set of measures. If that occurs, gEHRiMed™ would add those as MIPS QMs that are available for use. Either GPM, or another QCDR would report those measures to CMS.

How to Report Quality Measures if Not Reporting Through Claims (and receive a bonus for electronic reporting)

- Eligible Clinicians have the options of reporting quality performance measures via:
    - Qualified Clinical Data Registries (QCDR)
    - Registries
    - Certified Electronic Health Record Technology (CEHRT)
    - For groups of 25 or more clinicians, the GPRO WI reporting mechanism is an option:
        - Report on all applicable measures for a 248 patient sample selected by CMS.
        - The group will receive zeros for unreported measures and high priority measures will be eligible for bonus points (up to the 5% cap).

Recognizing the cost to report through electronic sources (CEHRT), CMS proposes bonuses for physicians who chose to report quality measures through an EHR, qualified registry, QCDR or web-interface. If eligible, a physician could earn one bonus point per each measure reported through an electronic source with a cap (up to a maximum of five percent of the denominator of the quality performance category score). This bonus is in addition to any bonus from scoring high priority measures.

Group Reporting

The CAHPS survey now appears to be voluntary for two or more clinicians in a group (even groups of 100 or more). If used as a quality measure, it would count for one of the six quality measures in either the patient experience domain or as the cross cutting measure. Clinicians are still responsible to pay for CAHPS to be administered by a CMS-approved survey vendor and must register to participate. The CAHPS survey would only be administered to Medicare Part B beneficiaries. An incentive has been proposed if CAHPS is used by a group; the group may report any five measures within MIPS plus the CAHPS for MIPS survey to achieve the six measures threshold.

The MIPS proposed scoring methodology would give bonus points to small groups for reporting CAHPS data (along with other patient experience measures.) CAHPS questionnaires are not designed for LTPAC

Medicine, so their use would require thoughtful patient/family education to achieve above average scores.

Full measures analysis forthcoming.

Resource Use

Equally weighted measures from claims (each measure will count for 1-10 points compared to historical benchmark (if available)) will be averaged to score this category:

- The total per capita costs for all attributed beneficiaries (Note the VM total per capita cost measures for the four condition-specific groups (chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, and diabetes mellitus) have been proposed not to be included any longer in MIPS.) The exclusion of patient attribution in POS 31 will reduce average per capita costs, but without additional refinement LTPAC patients will still be among the costliest.
- Medicare spending per beneficiary. There will be no adjustment for specialty in the MSPB calculation. The cost ratio used within the MSPB equation is proposed to be modified to evaluate the difference between observed and expected episode cost at the episode level before comparing the two at the individual or group level. MSPB is a calculation associated with total episode costs – and is attributed to the Physicians who provided inpatient hospital care. This should not affect providers who are exclusively LTPAC.
- Several additional episode-based measures to account for differences among specialties for the first performance year. The episode-based measures include Medicare Part A and Part B payments for services determined to be related to the triggering condition or procedure and attributed to the MIPS clinician. The measures will be payment-standardized and risk-adjusted and will include conditions and procedures that are high cost, have high variability in resource use, or are for high impact conditions. Episode groups will be further developed and refined over future years for purposes of the resource use category calculation.
- Attribution for the cost category will be at the individual or the group (TIN) level under MIPS, depending on how clinicians choose to report.
- TCM (CPT codes 99495 and 99496) and CCM codes (CPT code 99490) will be added to the primary care service definition to align with the MSSP.
- A minimum of 20 cases must be available to calculate each of the measures (MSPB, episode measures, and total per capita cost measures), the same case minimum that is being used for

the VM. MIPS eligible clinicians or groups that do not have enough attributed cases to meet or exceed the case minimums would not be measured on resource use.

- MIPS eligible clinicians who opt to have their performance measured as individuals across the other MIPS performance categories will have their resource use evaluated as individuals (TIN/NPI) based on cases specific to their practice, rather than being measured on all cases attributed to the group TIN.

Resource Use benchmarks will be based on the performance period; a MIPS eligible clinician's actual measure performance during the performance period will be evaluated to determine the number of points that should be assigned based on where the actual measure performance falls within these benchmarks. A single set of benchmark will be specified for each measure in the resource use performance category. All MIPS eligible clinicians that are attributed sufficient cases for the measure will be included in the same benchmark. A minimum of 20 MIPS eligible clinicians or groups must have the attributed 20 case minimum in order to develop the benchmark for each measure. If a MIPS eligible clinician is not attributed any resource use measures, then a resource use performance category score would not be calculated. For this category, lower cost will represent better performance. There will not be any bonus points in this category.

CMS proposes to improve the measurement of resource use and increase the weight of this category over time, taking weight from the quality category. Risk adjustment will continue to play as much of a role in the MIPS Resource Use category as it does in the current value modifier program under FFS. Along with Medicare Part A and Part B costs, the proposed rule indicates the cost of drugs under Part D may also be included in MIPS resource use as appropriate in the future.

- Services billed under CPT codes 99304-99318 in **POS 31 (**SNF) are proposed to be excluded from the definition of primary care services for MIPS under the Resource Use Criteria category to align with the Medicare Shared Savings Program. This is a significant change in attribution and will be certain to lower the average cost per patient, but the patient population attributed via POS 32 will still be vastly costlier than the population cared for in ambulatory practices.

CMS plans to make refinements to its attribution methodology starting in 2018, although this will not be in time for the 2017 reporting period, which will impact the 2019 payment adjustment.

Clinical Practice Improvement Activity (CPIA)

A Clinical Practice Improvement Activity is defined in MACRA as an activity that is identified as improving clinical practice or care delivery and is likely to result in improved outcomes. CMS proposes to allow physicians to select from a list of more than 90 activities in a CPIA inventory. This category is weighted 15% of the total MIPS Composite Performance Score, 60 points.

Activities will have high or medium weights. MIPS eligible clinicians participating as individuals or as groups may attest to three high-weighted CPIAs (20 points each) or six medium-weighted CPIAs (10 points each), or some combination of high and medium weighted CPIAs to achieve a total of 60 points. MIPS eligible clinicians or groups that select less than the designated number of CPIAs will receive partial credit based on the weighting of the CPIA selected. If a MIPS eligible clinician or group reports no CPIAs, then the MIPS eligible clinician or group would receive a zero score for the CPIA performance category. **This category will not measure performance, just participation.**

Activities that would count for CPIA in the first performance year ((NPRM Appendix Table H) include:

- Completion of the American Medical Association's STEPS Forward program;
- As a result of Quality Innovation Network-Quality Improvement Organization technical assistance, performance of additional activities that improve access to services (e.g., investment of on-site diabetes educator).
- Consultation of Prescription Drug Monitoring Program prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription that lasts for longer than 3 days.
- Use of a QDCR to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations. (A MIPS eligible clinician or group cannot receive credit for multiple activities just by selecting one activity that includes participation in a QCDR).
- Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare.
- Offer integrated behavioral health services to support patients with behavioral health needs, dementia, and poorly controlled chronic conditions. The use of telehealth (GT modifier) as assessed by claims
- Implementation of an antibiotic stewardship program
- Provide 24/7 access to MIPS eligible clinicians, eligible groups, or care teams for advice about urgent and emergent care (e.g., eligible clinician and care team access to medical record, cross-

coverage with access to medical record, or protocol-driven nurse line with access to medical record)

- Participation in a systematic anticoagulation program for 60% of practice patients in year 1 who receive anti-coagulants
- Use of telehealth services and analysis of data for quality improvement
- Empanel (assign responsibility for) the total population, linking each patient to a MIPS eligible clinician or group or care team and proactively manage chronic and preventative care for empaneled patients. (eg. Chronic Care Management)
- Risk stratify patients for longitudinal care management using a consistent method to assign and adjust risk status, personalize a plan or care, or proactively monitor and coordinate care for highest risk patients
- Provide episodic care management (timely follow-up to hospitalizations/ED visits, medication reconciliation).

CPIA activities must be performed for at least 90 days during the performance period; a minimum number of hours in the activity during that 90 days is not required. Activities, where applicable, may be continuing (that is, could have started prior to the performance period and are continuing) or may be adopted in the performance period as long as an activity is being performed for at least 90 days during the performance period.

A Patient Centered Medical Home (PCMH) would count for full credit in the CPIA category (100% or 60 points) if it is a national recognized accredited PCMH, a Medicaid Medical Home Model, or has a National Committee for Quality Assurance (NCQA) Patient-Centered Specialty Recognition. (See section on PCMH below) The proposed rule takes note of practices that may receive a patient-centered medical home designation at a practice level, but whose individual TINs may be composed of both undesignated practices and PCMH-designated practices (for example, only one practice site has received patient-centered medical home designation in a TIN that includes five practice sites). For MIPS eligible clinicians who choose to report at the group level, how credit will be provided for patient-centered medical home designations in the calculation of the CPIA performance category score for groups when the designation only applies to a portion of the TIN is to be determined in the final rule.

Those MIPS eligible clinicians or groups who are participating in a MIPS APM will earn at least 50% (30 points) for the CPIA performance category just by participating in the APM and may complete additional CPIA activities to score the remaining 30 points for this category to reach the highest score.

All MIPS eligible clinicians will be allowed to self-identify as part of an APM, a patient-centered medical home (PCMH) or comparable specialty practice, a Medicaid Medical Home or Medical Home Model, a non-patient facing professional, a small practice (consisting of 15 or fewer professionals), a practice located in a rural area, or a practice in a geographic HPSA or any combination thereof as applicable during attestation following the performance period. CMS will validate these self-identifications as appropriate.

Data for the CPIA performance category may be submitted using the qualified registry, EHR, QCDR, CMS Web Interface and attestation data submission mechanisms. If technically feasible, CMS will use administrative claims data to supplement the CPIA submission. Reporting in this category in 2017 through a health IT vendor, QCDR, and qualified registry will be done by designating yes or no for activities on the CPIA inventory list and the health IT vendor, QCDR, or qualified registry will submit the data on behalf of the eligible clinician or group. A single data submission agreement could be required for the MIPS program.

For MIPS eligible clinicians and groups that are small, located in rural areas or geographic HPSAs, or non-patient-facing MIPS eligible clinicians or groups, two CPIAs are required (either medium or high) to achieve the highest score of 100% or one CPIA is required (either medium or high) to achieve a 50% score.

If MIPS eligible clinicians have more than 60 CPIA points, a cap has been proposed so that the resulting CPIA performance category score remains at 100% or 60 points. The CPIA activity accounts for 15% of the total MIPS Composite Performance Score.

Full measures analysis forthcoming.

Advancing Care Information (replaces Meaningful Use)

- Moves away from a pass-fail program design by combining a Base Score and Performance Score into an overall ACI score. The Base Score (worth 50 percent of the overall ACI score) only requires attestation or simple yes/no options. The Performance Score does not utilize thresholds and allows physicians to receive partial credit on measures. Physicians can also receive a bonus point for reporting to multiple public health and clinical data registries.
- No longer requires physicians to report on two measures that hindered usability--computerized provider order entry (CPOE) and Clinical Decision Support (CDS). Removes clinical quality measures to streamline overall quality reporting in MIPS.
- Allows group data submission and performance to be assessed as a group (as opposed to the individual clinician). Permits physicians to submit data for the first time through QCDRs.
- The proposed rule would eliminate exclusions that many physicians took advantage of to avoid reporting on certain measures and requires new participants to start reporting under a full calendar year (instead of a 90-day reporting period).

Objectives for Reporting

These objectives include Patient Electronic Access, Coordination of Care through Patient Engagement and Health Information Exchange, which are essential to leveraging certified EHR technology to improve care. Six objectives will be required to achieve at least 50% (base score) in the Advancing Care Information performance category. Most notable changes from previous meaningful use criteria include the removal of Computerized Provider Oder Entry (CPOE) and Clinical Decision Support (CDS) from ACI requirements. The following six measures are required objectives and measures that eligible clinicians must report:

TABLE 6: Base Score Primary Proposal Advancing Care Information Objective and Measure Reporting*

	Objective	Measure*	Total Base Score
1	Protect Patient Health Information	Security Risk Analysis	50 %
2	Electronic Prescribing	ePrescribing	
3	Patient Electronic Access	Patient Access	
		Patient-Specific Education	
4	Coordination of Care Through Patient Engagement	View, Download or Transmit (VDT)	
		Secure Messaging	
		Patient-Generated Health Data	
5	Health Information Exchange	Patient Care Record Exchange	
		Request/Accept Patient Care Record	
		Clinical Information Reconciliation	
6	Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting	
		(Optional) Syndromic Surveillance Reporting	
		(Optional) Electronic Case Reporting	
		(Optional) Public Health Registry Reporting	
		(Optional) Clinical Data Registry Reporting	

Performance Score

MIPS eligible clinician would earn additional points above the base score for performance in the objectives and measures for Patient Electronic Access, Coordination of Care through Patient Engagement, and Health Information Exchange. The following graph provides an example of how the performance score is calculated:

TABLE 9: Sample Performance Score

Objectives	Patient Electronic Access		Coordination of Care Through Patient Engagement			Health Information Exchange (HIE)		
Measures	Patient Access	Patient-Specific Education	VDT	Secure Messaging	Patient-Generated health Data	Patient Care Record Exchange	Request/ Accept Patient Care Record	Clinical Information Reconciliation
Performance Rate Score								
	95%							
		65%						
								57%
			33%	31%			38%	
					25%	21%		
Percentage Points Earned	9.5%	6.5%	3.3%	3.1%	2.5%	2.1%	3.8%	5.7%
Performance Score = 36.5 percent								

Base Score Thresholds

In order to successfully achieve the base score requirements, eligible clinicians are required to have one single patient perform under that objective's measure, or report a "yes/no" statement as appropriate. Only "yes" answers for attestation objectives or measures will qualify as meeting the objective or measure. Previous thresholds under meaningful use are no longer applicable.

Calculating Performance Score

To determine the MIPS eligible clinician's overall advancing care information performance category score, we propose to use the sum of the base score, performance score, and the potential Public Health and Clinical Data Registry Reporting bonus point.

Base Score		Performance Score Components								Total Performance Score	Public Health and Clinical Data Registry Bonus Point	Total Percentage
Protect Patient Health Information	Objectives and Measures	Patient Electronic Access		Coordination of Care Through Patient Engagement			Health Information Exchange					
50%		9.5%	6.5%	3.3%	3.1%	2.5%	2.1%	3.8%	5.7%	36.5 %	1%	87.5%
87.5% of 25 possible percentage points = 21.88 percentage points for the advancing care information performance category												

The Advancing Care Information category will account for 25% of the MIPS Composite Score in 2017. The ACI performance category consists of a total of 131 possible points, of which only 100 points are required to receive the full 25 points in the Advancing Care Information category of the MIPS Composite Score.

Reporting Period

Under MIPS, the performance period for the advancing care information performance category to the proposed MIPS performance period of one full calendar year. There will be no 90-day reporting period under the proposed rule. However, if the eligible clinician only has data for a portion of the year, the eligible clinician can still participate in the Advancing Care Information category.

Reporting of Clinical Quality Measures

Eligible clinicians will no longer need to report CQM's as previously required by the meaningful use program as a part of Advancing Care Information. These requirements will be satisfied by reporting on criteria in the quality portion of MIPS. CMS continues to encourage ECs to use eCQMs in their Certified EHR.

Group Reporting

Under MIPS, reporting on advancing care information performance category objectives and measures can be reported at the group level, as opposed to the individual MIPS eligible clinician level. However, that the data submission criteria would be the same when submitted at the group-level as if submitted at the individual-level, but the data submitted would be aggregated for all MIPS eligible clinicians within

the group practice. Group reporting may lower the overall burden since one provider's report on a patient contributes to the group's reporting threshold [e.g. 90% for registry reporting].

Medicaid EHR Incentive Program & Advancing Care Information

The advancing care information performance category under MIPS cannot be used as a demonstration of meaningful use for the Medicaid EHR Incentive Programs. Similarly, a demonstration of meaningful use in the Medicaid EHR Incentive Programs cannot be used for purposes of reporting under MIPS. Therefore, MIPS eligible clinicians who are also participating in the Medicaid EHR Incentive Programs must report their data for the advancing care information performance category through the submission methods established for MIPS in order to earn a score for the advancing care information performance category under MIPS and must separately demonstrate meaningful use in their state's Medicaid EHR Incentive Program in order to earn a Medicaid incentive payment.

Certification Requirements

For 2017, the first MIPS performance period, MIPS eligible clinicians would be able to use EHR technology certified to either the 2014 or 2015 Edition certification criteria as follows:

If GPM attains the 2015 Edition Certification, eligible clinicians can choose to report on both ACI objectives and measures which are aligned with previous Stage 3 requirements of Meaningful Use, or report on Modified Stage 2.

If GPM has a combination of both 2015 Edition and 2014 Edition, eligible clinicians can choose to report both ACI objectives and measures which are aligned with previous Stage 3 requirements of Meaningful Use, or report on Modified Stage 2, if they have the appropriate mix of technologies to support each measure selected.

If GPM continues to maintain our 2014 Edition certification, a MIPS eligible clinician would be required to report on the alternate objectives and measures specified for the advancing care information performance category which correlate to modified Stage 2 objectives and measures.

According to the proposed rule, GPM must obtain the 2015 Edition to meet the objectives and measures specified for the advancing care information performance category for reporting in calendar year 2018.

During May 2016, the ONC announced that full 2015 Modified Stage 2 EHR Certification could not be completed until the MIPS ACI measures were finalized and incorporated into the Certification Testing protocols. GPM is assessing how this new policy affects our Certification Strategy. p.s. we really love the ability DHHS/CMS/ONC has to postpone their rules without making corresponding changes to the

performance requirements for providers and technology vendors.

Method of Data Submission

To report the Advancing Care Information performance category objectives and measures under MIPS, the data can be reported through qualified registry, EHR, QCDR, attestation and CMS Web Interface submission methods. Regardless of data submission method, all MIPS eligible clinicians must follow the reporting requirements for the objectives and measures to meet the requirements of the advancing care information performance category.

Method of Data Submission in CY 2017

2017 would be the first year that EHRs (through the QRDA submission method), QCDRs and qualified registries would be able to submit EHR Incentive Program objectives and measures to CMS, and the first time this data would be reported through the CMS Web Interface. More specific details about the form and manner for data submission will be addressed by CMS in the future.

Payment Adjustments

Like the current Value-Based Modifier Program, MIPS is a budget neutral program and positive fee adjustments will be scaled by a factor (x) according to the total amount of negative adjustments applied. The performance threshold will be issued prior to the performance period and will be based on the prior year's performance. A composite performance score is less than or equal to 25% to the threshold, MIPS clinicians will receive a maximum negative adjustment in 2019 of -4%.

POTENTIAL ADJUSTMENTS TO MEDICARE PAYMENTS BASED ON QUALITY PROGRAM PARTICIPATION

Program	2015/2017*	2016/2018*	2017/2019	2018/2020	2019/2021	2020/2022
PQRS	-2%	-2%	-	-	-	-
MU	-3%	-4%	-	-	-	-
VBPM	-4%/+4x	-4%/+4x	-	-	-	-
MIPS	-	-	-4%/+4x	-5%/+5x	-7%/+7x	-9%/+9x
APM	-	-	+5%	+5%	+5%	+5%

**Physicians will receive a .5 percent increase to the Medicare Physician Fee Schedule in 2017 and 2018 regardless of the negative or positive adjustments in the quality programs.*

MIPS Feedback

Feedback will be provided in the cost and the quality category beginning July 1, 2017. Feedback will be provided annually to start and then more frequently. Feedback will incorporate CPIA and ACI categories in the future.

Physician Compare

Information about MIPS performance will be included on Physician Compare.

DEFINING QP, APMS, ADVANCED APMS

"Qualifying APM Participants" (QPs)

Under MACRA's APM provisions, clinicians must satisfy the requirements of "Qualifying APM Participants" (QPs) by participating in an Advanced APM to be eligible for certain benefits, including:

- For payment years 2019 to 2024, a lump sum payment equal to 5 percent of the estimated aggregate payment amounts for Medicare Part B covered professional services for the prior year;
- Exclusion from MIPS; and
- For payment years 2026 and later, payment rates under the Medicare physician fee schedule for services furnished by the eligible clinician will be updated by the 0.75 percent qualifying APM conversion factor.

Clinicians must participate in an Advanced APM for at least one year to become a QP. Not all clinicians can qualify as QPs and be eligible for the bonus incentives and subsequent APM conversion factor. CMS indicates that these incentives are designed to be challenging and involve "rigorous care improvement activities."

Partial QPs

Practitioners that do not qualify as QPs may qualify as Partial QPs by meeting slightly lower payment amount or patient count thresholds. Partial QPs are not eligible for the 5 percent APM incentive payment or the APM conversion factor. However, they could decide whether or not to be subject to the MIPS payment adjustment (which could be positive or negative).

MIPS Alternative Payment Models

Clinicians may take part in an APM that is not advanced enough to qualify them as a QP to receive benefits under MIPS.

A MIPS APM includes any of the following:

(1) a model under section 1115A of the Act (other than a health care innovation award);
(2) the shared savings accountable care organization program under section 1899 of the Act;
(3) a demonstration under section 1866C of the Act; or
(4) a demonstration required by Federal law.

Participation in a MISP APM does not qualify a clinician for an APM incentive payment nor would exempt the clinician from MIPS. Rather, clinician must participate in an Advanced APM.

MIPS APM participants can potentially improve their MIPS scores by participating in APMs and reduce duplicative reporting if they are not in Advanced APMs and do not meet the revenue or patient thresholds to qualify for bonuses.

> *APMs (such as an ACO track 1) would report quality for them under the MIPS Quality Payment Program.*
>
> MIPS APMs will have their resource cost component weight reduced to zero, thus exempting them from this MIPS component. The 10% that would have been assigned to resource costs is used to increase weights for CPIA and HIT weights by 5% each. APM participation qualifies as CPIA; this is an advantage for participating physicians.

APM Entities

CMS proposes an APM Entity would be any participating entity in an APM, whereas an Advanced APM Entity would be one that participates in an APM that CMS has in fact determined to be an Advanced APM

Advanced Alternative Payment Models (AAPM)

Eligible clinicians and groups consisting of eligible clinicians may participate in the Quality Payment Program via an APM or Advanced APM (AAPM). Qualifying APM participants (QPs) are excluded from MIPS and will receive a 5 percent lump sum bonus for meeting reporting criteria beginning in 2019. In 2026, non-QPs participating may qualify for a 0.25 percent update, whereas QPs may receive a 0.75 percent update. The performance period, reporting, and payment year timeline is the same as for MIPS. These providers would take on substantial financial risk within the approved APMs in the program.

What Are Advanced APMs?

CMS proposes two types of Advanced APMs: Advanced APMs and Other Payer Advanced APMs. APMs seeking to qualify under either of these types must meet the following requirements:

- At least 50% of eligible clinicians must use certified EHRs;
- Pay providers based on quality measures comparable to those under MIPS; and
- Assume more than a "nominal risk" for financial losses OR be an accredited PCMH, expanded under section 1115A(c) of the Act.

According to the proposed rule, the only current models that qualify as Advanced APMs are:

- Medicare Shared Savings Program (MSSP) Tracks 2 and 3,
- Next Generation ACO model
- Oncology Care Model with two-sided risk,
- Comprehensive ESRD Care (large dialysis organization),
- Comprehensive Primary Care Plus (CPC+) model,
- Patient Centered Medical Homes (PCMH) expanded under CMMI authority (none exist at this time)

The rule indicates that CMS will continue to add to this list.

An Other Payer Advanced APM allows eligible clinicians to participate in an APM through other payers, such as a commercial plans or a state Medicaid program offering an APM, but these will not allow removal from the MIPS program until 2021.

The regulation indicates that most clinicians who participate in ACOs or other value-based payment

models may not meet the law's requirements to qualify for the Advanced APM track. The proposed rule provides financial rewards for those clinicians through MIPS, and allows them to transition between payment models.

Many clinicians who participate to some extent in Alternative Payment Models may not meet the law's requirements for sufficient participation in the most advanced models. CMS expects the number of providers who qualify to participate in the AAPMs will increase as the program matures.

Advanced APM performance period would be same as MIPS = 2017. Lump sum bonus payments would be made 18 months later in mid-2019.

APMs and Risk

One of the most important questions addressed by the proposed rule relates to the requirement that participants in APMs must bear "more than nominal financial risk" to be eligible for the Advanced APM payment. To determine whether an APM meets the nominal financial risk requirement, CMS proposes to measure three dimensions of risk: marginal risk, minimum loss rate and total potential risk. Marginal risk refers to the percentage of expenditures that the participant is responsible if actual costs exceed expected costs. Minimum loss rate refers to the percentage by which actual expenditures can exceed expected expenditures without triggering financial risk for the participant. Total potential risk refers to the total amount of financial risk for which the participant would be responsible. According to the proposed rule, APM participants would need to meet the following three criteria to satisfy the nominal financial risk requirement:

- Marginal risk must be at least 30%.
- Minimum loss rate must be no greater than 4%.
- Total potential risk must be at least 4% of expected expenditures.

If the APM risk arrangement meets the proposed financial risk standard, CMS would then consider whether the amount of the risk is in excess of a nominal amount. An APM takes on more than a nominal amount of risk if it meets certain thresholds tied to its actual and expected expenditures.

Practice investments and ongoing costs associated with APM are not counted as risk.

Patient Centered Medical Home (PCMH)

"Under the statute, medical home models that have been expanded under the Innovation Center authority qualify as advanced [alternative payment models (APMs)] regardless of whether they meet the financial risk criteria." No PCMH currently meet these criteria. Also, medical homes would be the APM Entities in an APM, not the APM itself.

A practice "is certified as a [PCMH]" if it achieves medical home accreditation from one of four accrediting bodies; if it's a Medicaid medical home model; or, for specialty practices, if it achieves specialty-specific accreditation from NCQA. Nationally recognized accredited patient-centered medical homes are recognized if they are accredited by: (1) the Accreditation Association for Ambulatory Health Care; (2) the National Committee for Quality Assurance (NCQA) PCMH recognition; (3) The Joint Commission Designation; or (4) the Utilization Review Accreditation Commission (URAC). The criteria for being a nationally recognized accredited patient-centered medical home is that it must be national in scope and must have evidence of being used by a large number of medical organizations as the model for their patient-centered medical home.

If a PCMH qualifies as an advanced APM, providers operating within a medical home will be eligible for a 5% payment boost in 2019. All advanced APMs, including the PCMH, also are excused from participating in MIPS -- but if you want to participate in MIPS, the PCMH offers additional incentives.
CMS proposes that medical homes will automatically achieve the "highest performance score" possible for the new addition -- the clinical practice improvement activity (CPIA) category -- of the MIPS quality-reporting program.

CMS states in the proposed rule that "MIPS eligible clinicians who are in a practice that is certified as a patient-centered medical home or comparable specialty practice ... shall be given the highest potential score for the CPIA performance category." CMS proposes a slightly different approach for clinicians participating in medical homes, which have little, if any, experience with financial risk.
For medical homes, maximum potential loss starts at 2.5% of total Medicare revenue for 2019 and increases to 5% in subsequent years. Medical homes may count as losses the potential loss of additional payments the APM participants are receiving such as monthly care management payments but other APMs cannot count these payments.

Physician Focused Payment Models

Physician Focused Payment Model proposals from stakeholders, such as specialty societies, will be submitted to the Physician-Focused Payment Models Technical Advisory Committee (PTAC) that was created by MACRA. NPRM proposes criteria for use by PTAC in reviewing the proposals. Payment models proposed to PTAC must be Medicare models, cannot be Other Payer models, and must be physician-focused, not other practitioners.

The Burden on Small Practices

Most practitioners will not be eligible to participate in the Advanced APMs. And while the MIPS thresholds for successful participation are intended to be calculated so that half of all participants are above the threshold and half below, *CMS itself projects that 87 percent of solo practitioners and 70 percent of practices with two to nine eligible practitioners will fall below the threshold and be subject to negative payment adjustments, resulting in a financial impact of $300 million and $279 million respectively.*

CMS estimates that MIPS would distribute positive and negative Medicare payment adjustments in 2019 to 687,000 – 746,000 eligible practitioners, amounting to $833 million in regular bonuses and $833 million in penalties, plus $500 million in special bonuses for exceptional performance. Another 30,000 – 90,000 eligible practitioners participating in Alternative Payment Models (APMs), such as advanced accountable care organizations (ACOs), could receive $146 million - $429 million in supplemental incentive payments under the proposed rules.

CMS PROJECTED IMPACT OF MIPS BY PRACTICE SIZE

Practice Size	Eligible Clinicians	Percent Eligible Clinicians with Negative Adjustment	Eligible Clinicians with Negative Adjustment	Percent Eligible Clinicians with Positive Adjustment	Eligible Clinicians with Positive Adjustment	Eligible Clinicians with no Adjustment	Aggregate Impact Negative Payment Adjustment ($ Mil)	Aggregate Impact Positive Adjustment ($ Mil)
Solo	102,788	87.00%	89,383	12.90%	13,302	103	-$300	$105
2-9 eligible clinicians	123,695	69.90%	86,519	29.80%	36,887	289	-$279	$295

Practice Size	Eligible Clinicians	Percent Eligible Clinicians with Negative Adjustment	Eligible Clinicians with Negative Adjustment	Percent Eligible Clinicians with Positive Adjustment	Eligible Clinicians with Positive Adjustment	Eligible Clinicians with no Adjustment	Aggregate Impact Negative Payment Adjustment ($ Mil)	Aggregate Impact Positive Adjustment ($ Mil)
10-24 eligible clinicians	81,207	59.40%	48,213	40.30%	32,737	257	-$101	$164
25-99 eligible clinicians	147,976	44.90%	66,515	54.50%	80,588	873	-$95	$230
100 or more eligible clinicians	305,676	18.30%	56,045	81.30%	248,626	1,005	-$57	$539
Overall	**761,342**	**45.50%**	**346,675**	**54.10%**	**412,140**	**2,527**	**-$833**	**$1,333**