

## **CMS Releases the Final Rule for the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).**

The Centers for Medicare and Medicaid Services (CMS) issued the *Medicare Program; Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models* final rule on October 14<sup>th</sup>, detailing implementation of MACRA and its constituent Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). The ACR responded to several key provisions impacting radiologists in the proposed rule from April 2016. Several of these comments were addressed in the final rule as summarized below.

### **Patient-Facing versus Non-Patient Facing Definitions and Thresholds**

#### *Threshold for patient-facing interactions for MIPS participation*

MACRA recognizes clinician practice diversity and allows for flexibility to address different practices, particularly calling for flexibility in the application of measures and activities required by “non-patient facing” clinicians such as radiologists, pathologists and anesthesiologists. In the MACRA proposed rule, CMS proposed some exemptions and options for non-patient-facing clinicians. The proposed rule suggested a threshold of 25 patient-facing encounters for both individuals and groups, which the ACR considered too low and that definition would result in many diagnostic radiologists and groups being considered patient facing. This threshold would have included approximately 30% of all radiologists as patient-facing. In the final rule, **CMS acknowledged these concerns and will “define a non-patient facing MIPS eligible clinician as an individual MIPS eligible clinician who bills 100 or fewer patient-facing encounters (including Medicare telehealth services defined in section 1834(m) of the Act) during the non-patient facing determination period, and a group provided that more than 75% of the NPIs billing under the group’s TIN meet the definition of a non-patient facing individual MIPS eligible clinician.”**

#### *Definition of patient-facing interactions*

The exact codes for determination of patient-facing interactions that determine what interactions are patient-facing have not yet been published by CMS. There lacks clarity as to whether the list of patient-facing codes will be limited to Evaluation and Management codes or consist of a larger set including some of the interventional radiology procedures that are 000 day global codes. **At present, the precise determination of whether radiologists will be required to report additional measures under MIPS as patient-facing versus non-patient-facing MIPS eligible clinicians cannot be assessed without knowing the specific codes for patient-facing interactions.**

This represents an important consideration for diagnostic radiologists not frequently involved in patient-facing interactions such as office visits, who may not be subject to the same extent of requirements for patient-facing MIPS reporting (as outlined in the reporting requirements) depending on the final definition concerning patient-facing interactions and particularly for groups that have one or more interventional radiologists where exceeding the non-patient facing threshold may occur.

### *Non-patient facing Clinician Descriptor*

Additionally, the ACR responded to the proposed rule that the terminology “non-patient facing”, while helpful for describing specific services, does not accurately represent the patient-centric role of the radiologist and the diversity of activities performed including patient interaction, coordination of care and consultation with other physicians. **In recognition of the ACR and others’ concerns about the inappropriateness of the term “non-patient facing” clinician for this purpose, CMS also seeks additional comment on alternatives to the current terminology for future consideration.**

### **Group versus Individual Participation**

#### *Group reporting threshold for non-patient facing eligibility*

Initially, the proposed MACRA rule made no provisions to account for the Group Practice Reporting Option (GPRO) with regard to thresholds for certain reporting requirements under the patient-facing eligible clinician definition. The final rule from CMS makes a key provision for **group practices to be treated as non-patient-facing as long as “more than 75 percent of the NPIs billing under the group’s TIN meet the definition of a non-patient facing individual MIPS eligible clinician.”**

#### *Reporting on a group level*

In the final rule, “Groups reporting at the group level will be assessed and scored, at the TIN level and have a MIPS payment adjustment applied at the TIN/NPI level.” Importantly, *all* performance data must be assessed as a group for all MIPS categories. These MIPS categories may be reported on a group basis to CMS directly or through third-party data submission services including qualified clinical data registries. The specific data submission methods for individual and group reporting are outlined in tables below.

As it has been in PQRS and the Value Modifier programs, in MIPS, groups will not be required to register to have their performance assessed as a group except for groups who submit data using the CMS Web Interface or who report the CAHPS for MIPS survey for the quality performance category. For all other data submission methods, groups must work with appropriate third party entities, such as Qualified Clinical Data Registries (QCDRs) as necessary to ensure the data submitted clearly indicates that the data represent a group submission rather than an individual submission. This allows a group more flexibility in deciding when and if to participate as a group.

**TABLE 1: Proposed Data Submission Mechanisms for MIPS Eligible Clinicians Reporting Individually as TIN/NPI**

<b>Performance Category/Submission Combinations Accepted</b>	<b>Individual Reporting Data submission Mechanisms</b>
Quality	Claims QCDR Qualified registry EHR Administrative claims (no submission required)
Cost	Administrative claims (no submission required)
Advancing Care Information	Attestation QCDR Qualified registry EHR
Improvement Activities	Attestation QCDR Qualified registry EHR Administrative claims (if technically feasible, no submission required)

**TABLE 2: Proposed Data Submission Mechanisms for Groups**

<b>Performance Category/Submission Combinations Accepted</b>	<b>Group Reporting Data Submission Mechanisms</b>
Quality	QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more) CMS-approved survey vendor for CAHPS for MIPS (must be reported in conjunction with another data submission mechanism.) and Administrative claims (no submission required)
Cost	Administrative claims (no submission required)
Advancing Care Information	Attestation QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more)
Improvement Activities	Attestation QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more) Administrative claims (if technically feasible, no submission required)

**Low-Volume Threshold Exclusion from MIPS**

Similar to the CMS proposals regarding non-patient-facing MIPS determination, the ACR expressed concern over relatively low thresholds for exclusion of low volume clinicians from MIPS, based on the level of billing charges and small volume of Medicare beneficiaries. **CMS increased the allowable charge threshold for MIPS exclusion for both individual and group reporting from**

**\$10,000 in the proposed rule to \$30,000 and maintained the volume exclusion of less than OR equal to 100 Medicare patients.** With this final rule, CMS also adjusted their proposal so that both the billing volume and patient threshold are not required to be met in order to be MIPS-exempt. These clinicians may elect to participate in MIPS but are not subject to MIPS payment adjustments. While these adjustments do not change group thresholds for low volume, CMS advises that practices have the option to report individually.

### **Small, Rural and Geographic Health Professional Shortage Area Practices**

These categories of practices receive special consideration under the finalized rule similar to that of non-patient facing clinicians. In addition, these practices are eligible for technical assistance in transitioning to the new Quality Payment Program (QPP). CMS defines small practices as a group of 15 or fewer eligible clinicians in its final rule. Rural practices are determined on the basis of zip code designation as rural using the HRSA Area Health Resource File. Medically underserved areas and health professional shortage areas will also receive similar benefits.

### **Performance Period**

The final rule stipulates that the QPP and its constituent MIPS and APMs will be effective January 1<sup>st</sup>, 2017. The ACR had proposed a delayed and abbreviated initial reporting period to begin in July 2017 to allow clinicians sufficient time to prepare for these substantial changes and facilitate collection of performance benchmarks for MIPS-related data. Instead of delaying implementation of the reporting period, CMS acknowledged the concerns of the ACR and others, and first introduced in September 2016 the concept that allows clinicians to select a pace of participation and determined that **the first reporting year (2017 performance year, 2019 MIPS payment year) will be treated as a transition year with reduced performance thresholds.** Providers will be expected to submit data about the care provided and how their practices used technology in 2017 to MIPS by the deadline of March 31, 2018.

### **Pick Your Pace**

In the final rule, four options were provided for physicians to participate in to allow physicians to avoid negative payment adjustments in 2019 while adapting to the new reporting requirements under QPP:

1. **Test the QPP.** Clinicians submitting partial data including data after January 1, 2017 will avoid a negative payment adjustment. CMS allows clinicians to choose to report one measure from the quality, improvement performance or advancing care information performance categories. An eligible clinician or group do not need to meet data completeness standards, e.g. 50% reporting, nor meet a minimum case threshold, i.e. 20 cases, in order to avoid the negative adjustment. *CMS also notes that MIPS eligible clinicians that choose not to report even one measure or activity will receive the full 4 percent negative adjustment.*
2. **Participate for part of the calendar year.** Data for the QPP may be submitted for part of the year (minimum of a continuous 90-day period) and allows clinicians to delay reporting within

the reporting period. Clinicians may potentially qualify for a small positive payment adjustment.

3. **Participate for the full calendar year.** Practices that are able to begin reporting QPP information beginning January 1, 2017 may qualify for positive payment adjustment.
4. **Participate in an Advanced Alternative Payment Model.** Under this plan, in lieu of reporting quality data and other information under MIPS, clinicians receive 5% positive payment adjustment in 2019 if enough Medicare patients or payments are performed in an Advanced APM.

### **Final Score Categories**

CMS reweighted the quality performance program criteria for patient-facing MIPS eligible clinicians as follows:

- Quality: 60% for the 2019 payment year, 50% for the 2020 payment year
- Cost: 0% for 2019, 10% for 2020 and 30% for 2021 payment years
- Advance Care Information: 25% for the 2019 payment year
- Improvement Activities: 15% for the 2019 payment year

**TABLE 30: Performance Category Redistribution Policies for the Transition Year (MIPS payment year 2019)**

Performance Category	Weighting for 2019 MIPS Payment Year	Reweight Scenario If No Advancing Care Information Performance Category Score	Reweight Scenario If No Quality Performance Category Score
Quality	60%	85%	0%
Cost	0%	0%	0%
Improvement Activities	15%	15%	50%
Advancing Care Information	25%	0%	50%

### **Reporting Criteria**

In its initial proposed rule, CMS proposed a Quality reporting threshold of 90% for QCDR reporting and 80% for claims-based reporting, which was reduced following input from the ACR and other stakeholders. CMS “will finalize a 50 percent data completeness threshold for claims, registry, QCDR, and EHR submission mechanisms” for 2017, with an increase to 60% in 2018 and potentially with additional increases in subsequent years. **This reduction in reporting threshold represents a significant improvement from the proposed rule and is consistent with the ACR’s comments on the proposed rule.**

#### ***Quality***

Within the new performance categories, MACRA reduced the reporting threshold for quality measures from nine under prior programs to six and eliminated the requirement to report across 3 National Quality Strategy domains. **Of the six measures reported, one should be an outcome measure, or if an outcome measure is not available, then another high priority measure should be**

**reported. CMS also did not finalize the requirement for reporting a cross-cutting measure by any clinician.** The removal of the cross-cutting measure reporting requirement from the proposed rule represents an important change.

Importantly, CMS sets forth an important consideration for clinicians unable to report enough quality measures, as stated in the final rule, “section 1848(q)(5)(F) of **the Act allows the Secretary to re-weight MIPS performance categories if there are not sufficient measures and activities applicable and available to each type of MIPS eligible clinician.**”

CMS describes considerations for validation of quality measures by submission mechanism, which is detailed in the final rule. **The claims and registry-based submissions will follow a cluster algorithm for validation similar to the existing PQRS measure applicability validation (MAV) process to determine whether a clinician has six applicable and available measures.** Notably, CMS comments that they expect clinicians enrolled in QCDRs will likely have adequate measures as part of the QCDR for reporting.

#### *Performance benchmarks*

CMS finalized a methodology for establishing measure benchmarks based on historical performance from a baseline period with publication of these benchmarks to be known in advance of the performance period. This is expected to be true for measures already included in the PQRS program for instance. There are exceptions made to this approach when no comparable data are available from the baseline period, in which case data from the performance period will be used to establish benchmarks after the end of the performance period.

Separate benchmarks will be used for the different submission mechanisms, i.e. EHR, QCDR, qualified registry, claims, Web interface, CAHPS survey vendor and administrative claims. CMS will not stratify benchmarks by other variables such as practice size.

#### *Improvement activities*

The number of required improvement activities were reduced by CMS in the final rule to ease reporting requirements further. For patient facing physicians, the number of activities required to achieve full credit was decreased from six medium-weighted or three high-weighted activities to four medium-weighted or two high-weighted activities to receive full credit in this performance category. Small, rural and health professional shortage area practices as well as, **non-patient facing MIPS clinicians will be expected to report only one high-weighted or two medium-weighted activities to meet the full performance criteria.** CMS included a list of over 90 activities listing their weightings in the final rule, which are available on the QPP website. Of relevance to radiologists, several QCDR-based activities are included as medium-weight measures and participation in the Transforming Clinical Practice Initiative (TCPI) such as with the ACR’s Radiology Support Communication and Alignment Network program (R-SCAN) is considered a high-weighted improvement activity.

#### *Advancing care information*

**The majority of ACR members would likely be reweighted to zero for the ACI category** on the basis that non-patient-facing eligible clinicians and hospital-based eligible clinicians will be automatically

reweighted by CMS without needing to manually apply for an exemption. In such case, the quality category would have a weight of 85 percent. Other eligible clinicians can apply to be reweighted to zero if they: (1) have insufficient Internet access; (2) face extreme and uncontrollable circumstances; or, (3) lack influence over CEHRT availability. If a clinician is reweighted to zero for ACI, these points would be reassigned to the quality category.

**The “hospital-based” determination mentioned in the above paragraph was changed in the final rule to include those who provide 75 percent or more covered professional services in the inpatient hospital (POS 21), on campus outpatient hospital (POS 22), or emergency room (POS 23) settings.** This is significantly different from the proposed “hospital-based” definition (which was first implemented in Meaningful Use [MU]) in that it lowers the threshold from 90 percent to 75 percent, and now includes outpatient hospital (POS Code 22) as a hospital setting instead of limiting the “hospital-based” determination to only inpatient and emergency room settings. Thus, the finalized definition will encompass more of ACR’s membership.

For eligible clinicians who are unable to qualify for reweighting this category to zero, **CMS reduced the total number of measures used in establishing ACI’s base score from eleven to five (for 50% of the ACI score) in its final rule**, with up to 90 percent performance score available from reporting up to nine measures, 5 percent bonus score available from registry participation measures, and up to 10 percent bonus score from improvement activities using CEHRT (only a 100% score is possible—overages do not provide extra credit). In the ACI category, activities must be performed for a period of at least 90 continuous days.

While the overall scoring methodology is more flexible, the individual measures are far more arduous for radiologist participants than the MU counterparts upon which they are based. For instance, ACI measures do not offer exclusions of any kind, meaning that no credit is given for measures that are irrelevant to one’s scope of practice. Typical diagnostic radiologist participants in MU have been excluded from having to report eleven to thirteen of the fifteen total measures that are used in ACI, including three of the five mandatory ACI measures that generate the base score. CMS argued in the final rule that removal of measure thresholds and improved scoring methodology render measure exclusions unnecessary; however, this would only be true for those clinicians who can report all base measures and a sufficient number of the performance and bonus measures to achieve the full ACI score. Therefore, any referral/procedure-based specialists who are unable to reweight ACI to zero would be at a significant disadvantage compared to primary care physicians and any specialists who manage patients over time (e.g., clinical oncologists, OBGYN, etc.).

#### *Cost*

**For all MIPS Eligible Clinicians, CMS reweighted the cost category to zero thereby exempting the category from the performance criteria for the first performance year (2017). CMS will still calculate cost measures** with the intent of providing clinicians with feedback regarding their cost performance during the first year. However, the final weighting will increase from 0% in 2019 to 10% in 2020 and finally to the 30 percent level required by MACRA by 2021. For MIPS eligible clinicians, CMS will calculate measures of total per capita costs for all attributed beneficiaries and a Medicare Spending per Beneficiary (MSPB) measure as well as episode-based measures. The threshold for inclusion in MSPB calculation was proposed at 20 cases but CMS finalized the

threshold at 35 cases for an individual or a group. In their cost calculations, CMS includes currently only 10 episode-based measures previously reported in the 2014 supplemental QRUR, which intend to capture the cost of treating a specific type of patient, but CMS intends to expand this list.

As a consultative specialty that spans numerous patient conditions, one of the major challenges for radiologists is the lack of control over resource uses and overall patient cost. CMS suggests that many non-patient facing clinicians may not have sufficient measures or meet the MSPB case minimum for any cost measure to be counted. However, non-patient facing clinicians are not expressly exempted from cost. As such, a radiologist (whether patient-facing or not) meeting the minimum number of cases would have these cost measures attributed and a cost performance score assigned.

### **Alternative Payment Models (APMs) and Advanced APMs**

While the number of clinicians participating in Advanced APMs rather than MIPS is a minority of all clinicians, participation in an Advanced APM has important implications for clinicians in providing a 5% incentive for appropriate levels of participation and excluding them from MIPS. CMS recognized the need for additional guidance concerning what Advanced APMs qualify and plans on “completing an initial set of Advanced APM determinations” that will be released by January 1, 2017.

**While CMS has not yet finalized details of additional advanced APMs, CMS is actively working to develop new models including a new Medicare Accountable Care Organization (ACO) Track 1+ model to begin in 2018, and other models. In addition, CMS is working on modifying current APMs, such as the Maryland All-Payer Model and Comprehensive Care for Joint Replacement (CJR) model to qualify as Advanced APMs.**

#### **Advanced APMs**

In order for an APM to qualify as an Advanced APM, CMS requires: (1) use of certified electronic health record technology (CEHRT); (2) payment based on quality measures comparable to those in the quality performance category under MIPS; and (3) meeting a financial risk standard.

#### *Bear more than a nominal amount of risk for monetary losses*

CMS proposed that for an APM to meet the nominal amount standard, (1) the specific level of marginal risk must be at least 30% of losses in excess of expected expenditures: (2) a minimum loss rate, to the extent applicable, must be no greater than 4% of expected expenditures: and (3) total potential risk must be at least 4% of expected expenditures. **CMS modified the Advanced APM nominal amount standard in the final rule to the payment amount the APM potentially forgoes from or owes to CMS must be: (1) 8% of “the average estimated total Medicare Parts A and B revenues of participating APM Entities (the revenue-based standard)” or (2) 3% of “the expected expenditures for which an APM Entity is responsible under the APM (the benchmark-based standard).”** The financial risk standards for Other Payer Advanced APMs that may qualify are similar to the proposed rule in requiring a marginal risk rate of at least 30% and total potential risk of at least 4% of expected expenditures.



## **Physician-Focused Payment Models**

Physician-focused payment models (PFPMs) are defined as “an Alternative Payment Model wherein Medicare is a payer, which includes eligible clinicians that are EPs as defined in section 1848(k)(3)(B) of the Act are participants and play a core role in implementing the APM’s payment methodology, and which targets the quality and costs of services that eligible clinicians participating in the Alternative Payment Model provide, order, or can significantly influence.”

In developing new models for eventual consideration as either APMs or Advanced APMs, proposed PFPMs are submitted to the Physician-Focused Payment Model Technical Advisory Committee (PTAC), which is an independent advisory committee to the Secretary. CMS does not specify many of the details of this process, which is based on a method chosen by the PTAC. If accepted by the PTAC, CMS then considers the PFPM, reviews the merits of its design and may suggest additional changes prior to testing. These may then meet criteria for inclusion as qualifying APMs or Advanced APMs.

**CMS finalized the PFPMs criteria as proposed with one modification to the proposed scope criterion, which “broadens or expands the CMS APM portfolio by addressing an issue in payment policy in a new way or including APM Entities whose opportunities to participate in APMs have been limited.”**

The ACR staff and MACRA Committee are currently reviewing the final rule and will prepare comments to CMS by close of the comment period on December 19.

## **Additional Information**

Below are links to the CMS MACRA MIPS/APM fact sheet and the Department of Health and Human Services (HHS) press release regarding the MACRA MIPS/APM final rule. In addition, a new Quality Payment Program website was created to explain the details of the new program.

(<https://qpp.cms.gov/>)

MACRA MIPS/APM Final Rule link: <https://qpp.cms.gov/docs/CMS-5517-FC.pdf>

MACRA MIPS/APM Final Rule Press Release link: <http://www.hhs.gov/about/news/2016/10/14/hhs-finalizes-streamlined-medicare-payment-system-rewards-clinicians-quality-patient-care.html>

MACRA MIPS/APM Final Rule Fact Sheet link:

[https://qpp.cms.gov/docs/Quality\\_Payment\\_Program\\_Overview\\_Fact\\_Sheet.pdf](https://qpp.cms.gov/docs/Quality_Payment_Program_Overview_Fact_Sheet.pdf)

MACRA Quality Payment Program Executive Summary link:

[https://qpp.cms.gov/docs/QPP\\_Executive\\_Summary\\_of\\_Final\\_Rule.pdf](https://qpp.cms.gov/docs/QPP_Executive_Summary_of_Final_Rule.pdf)