

ACR Issues Analysis of Proposed MACRA MIPS Rule

The Centers for Medicare and Medicaid Services (CMS) issued a proposed rule (CMS-5517-P) on April 27, 2016, to establish many of the provisions of Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) including the Merit-based Incentive Payment System (MIPS) and incentives for provider participation in specified Alternative Payment Models (APMs). The proposal is now subject to a 60-day comment period ending on June 27.

The new payment program is now known as the Quality Payment Program (QPP), which includes MIPS and qualified APMs. The rule proposes a framework for Physician-Focused Payment Models (PFPM), criteria for the Physician-Focused Payment Model Advisory Committee (PTAC) to provide comment and recommendations regarding these models and a process by which PFPM's would be tested and implemented after CMS review. It also includes a proposed [acronym list](#).

The passage of MACRA repealed the flawed Sustainable Growth Rate (SGR) policy, a methodology for adjusting Medicare's payments to physicians in concordance with changes in gross domestic product, and replaced it with the MIPS, which consolidated and renamed previously existing CMS quality programs components (PQRS, VM and Medicare EHR Incentive program/Meaningful Use) into one program having four components — Quality, Resource Use (RU), Clinical Practice Improvement Activities (CPIA) and Advancing Care Information (ACI).

MIPS

1. The MIPS-eligible clinicians include fee-for-service physicians, physician assistants, nurse practitioners, clinical nurse specialists and nurse anesthetist who continue in fee-for-service Medicare.
2. The four performance category scores would be aggregated into a composite score which would then be compared to a MIPS performance threshold to determine whether an eligible clinician receives an upward or downward payment adjustment, no adjustment, or in the case of exceptional performance, an additional positive adjustment factor.
 - i. The payment adjustments would be scaled to maintain statutorily mandated budget neutrality.
3. Performance category weighting, as well as scoring within performance categories can vary depending on practice size, rural location and whether clinician is deemed patient facing or non-patient facing. Proposed definition for patient facing versus non-patient facing clinicians will depend on a yet-to-be released CPT list. If a clinician bills any such patient facing code more than 25 times in a calendar year, he or she will be deemed patient facing. The rule is also proposing an identical definition for groups that report via the GPRO mechanism, therefore defining radiology groups, specific to one Tax Payer ID, as patient facing if they have interventional radiologists, mammographers or with diagnostic radiologists who bill more than 25 patient facing CPT codes in total during the reporting period.
4. CMS is proposing to collect measures and activities within four performance categories each with a separate set of specific standards:

a. **Quality**

- i. The category is worth 50 points (for first year of MIPS) out of the 100 possible under the total MIPS composite score. The category value will phase downwards to 30 points, while RU will phase upwards to 30 points over several years.
- ii. Quality measures will be selected annually through a call for quality measures process — based on criteria that align with CMS priorities and published in the Federal Register by the first of November of each calendar year. A list of proposed measures can be found in Appendix E. The available measures for reporting into Qualified Clinical Data Registries (QCDR) are defined by separate process and not included in Appendix E.
- iii. A minimum of six measures are to be reported by the clinician or group agnostic of the reporting mechanism. An additional three population measures will be used by CMS calculated from claims data (not requiring any submission by the clinician). These three measures are calculated via claims data and include two from the Agency of Health Care Research and Quality (AHRQ) Preventative Quality Measures (PQI) seen in table B of the rule, as well as All-cause hospital readmission rates. Groups with less than 10 doctors are exempt from the All-cause hospital readmission metric. Doctors with less than 20 attributed beneficiaries will be exempt from PQI.
- iv. At least one **cross-cutting measure** (for patient-facing MIPS Eligible clinicians or groups only)
- v. An outcome measure, if available
 1. If not available, another **high-priority** measure
 - a. Appropriate use
 - b. Patient safety
 - c. Efficiency
 - d. Patient experience
 - e. Care coordination
- vi. Proposed bonuses for reporting more than the one required outcomes measure and/or any high-priority measures. Maximum bonus of 5 percent of total point denominator.
- vii. Proposed bonus for using Qualified Clinical Data Registries (including ACR National Radiology Data Registries) or Certified Electronic Health Records Technology (CEHRT) to submit quality measures. Maximum bonus of 5 percent of total point denominator.
- viii. Ninety percent of all patients required to be submitted for QCDR. Eighty percent of Medicare patients required for claims based (Reporting Rate). Unlike PQRS, which only required a reporting rate, this category now includes a “performance rate” calculation on submitted measures. The performance rate calculation was previously calculated as part of the quality component under the Value Modifier program.
- ix. A maximum total of 90 points is awarded in this category, with 10 for each measure (6 submitted, and 3 calculated). You may only have 60 maximum points if you are excluded from the population measures. Performance score is calculated by dividing total number of earned points by the total number of eligible points. You may earn more than 100 percent with bonuses.

b. Cost

- i. The category is worth 10 points (for first year of MIPS) out of the 100 possible under the total MIPS composite score. The category will eventually have a value of 30 points phased in over several years. The additional 20 points will be taken from the Quality performance category.
- ii. The resource use category will initially model the VM using the total per costs capita for all attributed beneficiaries and Medicare spending per beneficiaries (MSPB) obtained from Medicare claims data. Resource Use will not contain a quality “performance rate” calculation as it did under the Value Modifier. This calculation has now been moved to the Quality performance category.
- iii. The resource use category also includes applicable episode-based measures for MIPS eligible clinicians.
- iv. Proposed reweighting of this category to zero is described in the rule addressing the concerns for assigning a performance score to non-patient facing clinicians or groups.

c. Clinical Practice Improvement Activities (CPIA)

- i. The category is worth 15 points out of the 100 possible under the total MIPS composite score.
- ii. This is a new performance category introduced under MACRA. The proposed rule describes different reporting criteria depending on whether or not the clinician or group is patient facing. Patient facing clinicians or groups will need to score 60 points with activities ranging in value from 10–20 points. This means 3–6 activities need to be chosen for compliance. Non-patient facing clinicians or groups need only report 2 activities (agnostic of individual value of the activity) to receive full credit (60 points). The list includes credit for using ACR QCDR or participating in the ACR R-Scan. It also includes TCP/SAN grants such as ACR R-Scan. Ninety+ activities are listed in Appendix H of the rule. More than 15 activities require QCDR participation.

d. Advancing Care Information. This program is a rebranding of the Meaningful Use program designed for encouraging proper use of CEHRT.

- i. The category is worth 25 points out of the 100 possible under the total MIPS composite score.
- ii. Six required objectives each with associated measures are required to achieve a base score of 50. The objectives are patient data protection, Health Information Exchange, Patient Access, E-prescribing, Coordination Through Patient Engagement and Registry Reporting (Immunization Registry required except when noted in iii).
- iii. Clinicians or groups who do not administer immunizations, therefore, are excluded from this requirement. They may choose to report to other registry options provided including QCDR. Exclusions are also offered for clinicians and groups in the E-prescribing category if they write fewer the 100 prescriptions during the performance period.
- iv. An additional performance score worth up to 80 is achieved with additional activities in Patient Electronic Access, Coordination of Care through Patient Engagement or Health Information Exchange.
- v. One-point bonus (maximum) is given to reporting to more than one registry. Immunization registry is required as part of the base score.

- vi. Total score possible is 131, however, CMS proposes all clinicians scoring 100 or more receive full credit.
 - vii. The rule proposes reweighting of this performance category to zero for non-patient facing clinicians or groups.
5. Reweighting of the 4 performance categories is proposed. Two options are provided, and CMS is requesting comments on which is preferred.
- i. Option one is reweighting all categories points weighted as zero into the Quality performance category.
 - ii. Option two is to split the points evenly between all remaining performance categories.
 - iii. Example: Diagnostic radiologist would meet the criteria for reporting Quality and Clinical Practice Improvement Activities, but may not meet the criteria for reporting Resource Use of ACI. In this scenario, the RU points (10 for first year) and the ACI points (25) could either all be placed into Quality (50+25+10=85) + CPIA 15 = 100, or split amongst Quality and CPIA evenly.
6. A number of Medicare-enrolled practitioners would be **excluded from MIPS**, including:
- a. Qualifying APM Participants (QPs)
 - b. Certain partially qualifying APM Participants (Partial QPs)
 - c. Clinicians that do not meet the proposed low-volume threshold. Qualified MIPS participants are now defined as MIPS eligible clinicians rather than EPs (Eligible Professionals).
 - d. 1st year Medicare participants.
7. CMS is proposing to allow MIPS eligible Physicians to maintain the flexibility to **submit information** individually or as a part of a group or APM Entity group.
- a. Regardless of how the MIPS eligible clinician reports, they would use the same identifier in all categories.
 - b. All submitted measures for all performance categories are either submitted as TIN/NPI for individuals or TIN for GPRO.
8. The rule proposes a **performance period** of one calendar year (January 1 through December 31) for applicable measures and activities, further proposing to utilize the 2017 performance period for 2019 adjustments, a timeframe which would allow for data and claims to be submitted and for analysis to take place.
9. CMS is proposing to include **feedback** regarding the quality and resource use performance categories to MIPS-eligible clinicians beginning July 1, 2017. CMS is planning on providing performance feedback annually and potentially more frequently in future years. CMS is additionally considering providing performance feedback on the CPIA and Advancing Care Information categories as well as leveraging Health IT vendors, registries and QCDRs in order to distribute the feedback.
10. CMS is proposing to allow third party **submission** of data to the MIPS through registries, QCDRs, Health IT Vendors and CMS-approved Survey Vendors.
11. If the proposals within the rule are finalized, MIPS information will be made publicly available in an easily understood format through the **Physician Compare Website**.

12. Impact table included in the rule:

Provider Type	Number of Physicians and Other Clinicians	Allowed Charges (mil)	Percent with negative payment adjustment	Percent with positive payment adjustment	Aggregate Impact Negative Payment Adjustment (mil)	Aggregate Impact Positive Payment Adjustment (mil)	Aggregate Positive Adjustment, Excluding Exceptional Performance Payment (mil)	Aggregate Positive Adjustment, Performance Payment Only (mil)
Radiology	34,998	\$4,165	49.20%	50.40%	(\$49)	\$65	\$41	\$24
Interventional Radiology	1,780	\$337	40.40%	59.20%	(\$4)	\$6	\$4	\$2
Radiation Oncology	4,239	\$1,513	44.20%	55.40%	(\$16)	\$27	\$17	\$10

APMs

13. In the rule, CMS proposes standards for use in the Alternative Payment Model (APM) incentive.

- a. Definitions
 - i. CMS proposes to define the term “Other Payer APMs” to speak to arrangements wherein eligible clinicians participate through other payers.
 - ii. CMS additionally defines the term “APM Entity” to refer to an entity that participates in an APM through a contract with a payer.
- b. CMS proposed criteria to allow APM’s to be considered Advanced APM’s if they meet three requirements including:
 - i. Requiring participants to use Certified EHR technology
 - ii. Providing payment for covered professional services based on quality measures categories comparable to those used under the MIPS
 - iii. Become a Medical Home Model or bear more than a nominal amount of risk for monetary loss.
- c. CMS proposes to notify the public of which APMs have been classified as Advanced prior to each QP performance period beginning no later than January 1, 2017.
- d. MACRA provides a threshold and options for determining whether the level of participation an eligible clinician maintains is enough to be considered a QP for each year.
 - i. The first option is the **Medicare Option** and it is based on Part B payments for covered professional services or the counts of patients who are provided covered professional services under Part B and begins to apply in 2019.
 - ii. The second option is the **All-Payer Option**, which is based upon a combination of the Medicare Option and an eligible clinician’s participation in Other Payer Advanced APMs to be recognized in future years.
- e. CMS is proposing the identification of individual eligible clinicians using a unique APM identifier based on TIN/NPI combinations. In addition, CMS is proposing that eligible clinicians who do not meet the threshold for QP status after participation in any individual APM Entity may be given **QP status** based on combined participation in multiple Advanced APMs.

- f. CMS proposes a method for **calculating and disbursing APM incentive payments**, rules for calculating APM Incentive payments when a QP also receives non-fee-for-service payments or adjustments through the HER incentive program, PQRS, VM or MIPS.
- g. CMS proposes a process for eligible clinicians to choose whether or not they would choose to subject themselves to MIPS payment adjustments if they qualify for consideration as Partial QPs (deemed intermediate option).
- h. The rule proposes a **definition for Physician-Focused Payment Models**, criteria for the Physician-Focused Payment Model Advisory Committee (PTAC) to provide comment and recommendations regarding these models, and a process by which PFPMs would be tested and implemented by CMS after Review.

SUMMARY OF COSTS AND BENEFITS

- 14. The requirements of MACRA would distribute payment adjustment to between 687,000 and 746,000 eligible MIPS clinicians in 2019 based on their performance on specified measures and activities within the four performance categories.
- 15. The payment adjustments will be equally distributed at \$833 million positive and negative payment adjustments in order to maintain budget neutrality.
- 16. The proposed provision on the MIPS to provide exceptional performance payments to Eligible Clinicians would distribute roughly \$500 million, though this number is subject to change depending on the final population of eligible clinicians.
- 17. CMS estimates that between 30,658 and 90,000 eligible clinicians would become QPs via participation in Advanced APMs, and would be estimated to receive between \$146 and \$429 million in incentive payments for CY 2019.