**Summary CMS Proposed Rule[[1]](#footnote--1)**

**Merit-Based Incentive Payment System (MIPS) and**

**Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and**

**Criteria for Physician-Focused Payment Models**

The Centers for Medicare and Medicaid Services (CMS) recently released a [proposed rule](https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf" \t "_blank) establishing two physician payment systems authorized in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) that permanently “fixed” Medicare physician payment. These two systems, the Merit-based Incentive Payment System (MIPS) and the Alternative Payment Models (APM), change the way Medicare incorporates quality metrics into physician payments. CMS has named these two systems collectively the **Quality Payment Program** (QPP).

**Timeline**: MIPS and APMs will go into effect incrementally from 2015 through 2021 and beyond. In 2016-2019, EPs will receive current fee schedule payments with a 0.5% annual adjustment. CMS proposes to begin measuring and analyzing performance for doctors and other clinicians through MIPS in January 2017, with MIPS payments based on those measures beginning in 2019. In order to determine whether clinicians met the requirements for the Advanced APM track, all clinicians choosing this system will report through MIPS in the first year. (See Appendix: Timelines for more information.)

Comments are due June 27, 2016 11:59 PM ET.

**Eligible Professionals (EP):** In the first two years of the payment system, CMS proposes that EPs would be physicians, physician assistances, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists. In years three and beyond, CMS proposes to include other clinicians that have been reporting quality measures under the current physician quality reporting system or Physician Quality Reporting System (PQRS) for a number of years such as physical and occupational therapists, clinical social workers, audiologists, audiologists, certified curse midwives and clinical psychologists/counselors.

**Merit-Based Incentive Payment System**

MIPS combines parts of the PQRS, the [Value Modifier](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html) (VM or Value-based Payment Modifier) and the Medicare Electronic Health Record (EHR) incentive program into one single program. MIPS will pay Medicare EP for providing high quality, efficient care through success in four performance categories.

CMS proposes to compute a score for each of the category and weigh it as described below to calculate composite performance scores (CPS). The MIPS CPS would be compared against a MIPS performance threshold. The CPS would be used to determine whether a MIPS eligible clinician receives an upward payment adjustment, no payment adjustment, or a downward payment adjustment to their Medicare Part B payments[[2]](#footnote-0). The CPS would also be used to determine whether a MIPS eligible clinician qualifies for an additional positive adjustment factor for exceptional performance.

**Performance Categories:**

* Quality: 50 percent of total score in year 1[[3]](#footnote-1); replaces the Physician Quality Reporting System and the quality component of the Value Modifier Program).
  + Clinicians report six measures of their choice versus the nine measures currently required under the Physician Quality Reporting System.
    - One measure must be a cross cutting measure (care plan, documentation of current medication in medical record, closing the referral loop: receiving specialists report, preventive care and screening)
    - One measure must be an outcome measure or a high priority measure (appropriate use, patient safety, efficiency, patient experience, and care coordination measures)
  + This category gives clinicians reporting options to choose from to accommodate differences in specialty and practices.
* Resource use: 10 percent of total score in year 1[[4]](#footnote-2); replaces the cost component of the Value Modifier Program (also known as Resource Use).
  + The score would be based on Medicare claims, meaning there are no reporting requirements for clinicians for this category.
  + T to account for differences among specialties, this category would use more than 40 episode-based measures, such as those for Mastectomy for Breast Cancer, Rheumatoid Arthritis or Carotid Endarterectomy.
* Clinical practice improvement activities: 15 percent of total score in year 1[[5]](#footnote-3); Clinicians would be rewarded for clinical practice improvement activities such as activities focused on care coordination, beneficiary engagement, and patient safety.
  + Clinicians may select activities that match their practices’ goals from a list of more than 90 options.
  + Clinicians will receive additional credit for each of the activities they undertake.
  + In addition, clinicians would receive credit in this category for participating in Alternative Payment Models and in Patient-Centered Medical Home.
* Advancing Care Information: 25 percent of total score in year 1[[6]](#footnote-4); Replaces the Medicare EHR Incentive Program for physicians, also known as “Meaningful Use”):
  + Clinicians would choose to report customizable measures that reflect how they use electronic health record (EHR) technology in their day-to-day practice, with a particular emphasis on interoperability and information exchange.
  + Unlike the existing Meaningful Use program authorized in the Obama stimulus legislation of the American Recovery and Reinvestment Act of 2009 (ARRA) by the HiTech Act, this category would not require all-or-nothing EHR measurement or quarterly reporting.

**POSSIBLE BUSINESS OPPORTUNITIES FOR MAXIMUS**

* **Third Party Submission Survey Vendor**: CMS is proposing to allow third party submission of data to the MIPS through registries, Qualified Clinical Data Registries[[7]](#footnote-5), Health IT Vendors and CMS-approved Survey Vendors. CMS proposed that survey vendors must submit to CMS audits of data submitted to CMS for MIPS calculation.
* **Targeted Review/Review of MIPS Calculation:** CMS propose to adopt a targeted review process under MIPS wherein a MIPS eligible clinician may request that CMS review the calculation of the MIPS adjustment factor and, as applicable, the calculation of the additional MIPS adjustment factor applicable to such MIPS eligible clinician for a year. CMS also proposes a general process by which a MIPS eligible clinician could request targeted review. CMS requests comments on the proposed targeted review.
  + **Note:** As the targeted review process is informal and the statute does not require a formal appeals process, CMS proposes to not include a hearing process. The MIPS eligible clinician may submit additional information to assist in their targeted review at the time of request.Decisions based on the targeted review will be final, and there will be no further review or appeal.

**Alternative Payment Models (APMs)**

An Advanced APM provides a path through which eligible clinicians can become a Qualifying APM Professional and earn incentive payments for participating in the APM. To be an Advanced APM, an APM must meet three requirements:

1. Require participants to use certified EHR technology;
2. Provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of MIPS; and
3. Be either a Medical Home Model expanded under section 1115A of the Act or bear more than a nominal amount of risk for monetary loses.

The proposed rule includes a list of models that would qualify under the terms of the proposed rule as Advanced APMs including

* Comprehensive ESRD Care Model (Large Dialysis Medicare Shared Savings Program—Track 3 Organization arrangement)
* Next Generation ACO Model
* Comprehensive Primary Care Plus (CPC+)
* Oncology Care Model Two-Sided Risk Arrangement
* Medicare Shared Savings Program—Track 2 (available in 2018); and

CMS would update this list annually to add new payment models that qualify to be an Advanced APM. The proposed rule also establishes the Physician-Focused Payment Technical Advisory Committee to review and assess additional physician-focused payment models suggested by stakeholders.

To qualify for incentive payments, clinicians would have to receive enough of their payments or see enough of their patients through Advanced APMs. Clinicians will have the option to be assessed as a group to qualify for incentive payments. The level of participation in an Advanced APM required to receive an incentive payment increases over time. (See “Participation Levels Required in Advanced APM to Receive Incentive Payment Increase” in Appendix Timelines.)

In 2019 and 2020, the participation requirements for Advanced APMs are only for Medicare payments or patients. Starting in 2021, the participation requirements for Advanced APMs may include non-Medicare payers (such as private insurers or state Medicaid programs) and patients.

CMS estimates that as many as 90,000 clinicians could receive the bonus for substantially participating in Advanced APMs in the first payment year.

MACRA did not change how any particular APM rewards value. Instead, it creates extra incentives for participation in Advanced APMs. For years 2019 through 2024, a clinician who meets the law’s standards for Advanced APM participation is excluded from MIPS adjustments and receives a 5 percent Medicare Part B incentive payment. For years 2026 and later, a clinician who meets these standards is excluded from MIPS adjustments and receives a higher fee schedule update than those clinicians who do not significantly participate in an Advanced APM.

CMS does not intend to create additional performance assessments or audits beyond those specified under an APM. Rather, the process for determining whether an eligible clinician receives the APM Incentive Payment should focus on the relative degree of participation by eligible clinicians in Advanced APMs, not on their performance within the APM. Thus, physicians and other EPs are highly incentivized to participate in APMs to avoid downward payment adjustments under MIPS.

**APPENDIX: Timelines**

**MIPS/APM Payment Timeline**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| **Fee schedule Update** | 0.5 | 0.5 | 0.5 | 0.5 | 0 | 0 | 0 | 0 | 0 | 0 |
| **MIPS Payment Adjustment (+/-)** |  |  |  | 4% | 5% | 6% | 9% | | | |
| **Advanced APM Participant** |  |  |  | 5%  Excluded from MIPS | | | | | | |

**Composition of** **Performance Categories Scores**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| **Quality** | 50% | 45% | 30% | | | | |
| **Resource Use** | 10% | 15% | 30% | | | | |
| **Clinical Practice Improvement**  **Activities** | 15% | | | | | | |
| **Advancing Care Information** | 25% | | | | | | |

**Participation Levels Required in Advanced APM to Receive Incentive Payment Increase**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **2019** | **2020** | **2021** | **2022** | **2023** | **2024+** |
| **% of Payments through an advanced APM** | 25% | 25% | 50% | 50% | 75% | 75% |
| **% of Patients**  **through an advanced APM** | 20% | 20% | 35% | 35% | 50% | 50% |

1. RIN 0938-AS69; <https://www.regulations.gov/#!documentDetail;D=CMS-2016-0060-0068>; May 9, 2016. [↑](#footnote-ref--1)
2. In the first year, depending on the variation of MIPS scores, adjustments are calculated so that negative/positive adjustments can be no more than 4 percent. They increase to +/- 5 percent in 2020, +/-7 percent in 2021 and +/- 9 percent for 2022 and after. See “MIPS/APM Payment Timeline” in Appendix: Timelines. [↑](#footnote-ref-0)
3. This performance category will account for 50 percent of the total MIPS score in year 1 (payment year 2019); 45 percent in year 2, and 30 percent for the third and future years. See “MIPS/APM Payment Timeline” in Appendix: Timelines. [↑](#footnote-ref-1)
4. The resource use performance category shall make up no more than ten percent of the CPS for the first MIPS payment year (CY 2019) and not more than 15 percent of the CPS for the second MIPS payment year (CY 2020). Beginning with the third MIPS payment year and for each MIPS payment year thereafter, the resource use performance category would make up 30 percent of the CPS. See “Composition of Performance Categories Scores” in Appendix: Timelines. [↑](#footnote-ref-2)
5. The CPIA category accounts for 15 percent of the MIPS score in year one of the program, and clinicians would receive credit for participating in APMs and Primary Care Medical Homes (PCMHs). CMS proposes to determine a clinician’s score by weighting activities on which they report; highly - weighted activities would be worth 20 points and lesser activities worth 10 points – with 60 points being the maximum total awarded. Highly weighted activities would be those activities supporting PCMHs, clinical practice transformation, and/or a public health priority. See “Composition of Performance Categories Scores” in Appendix: Timelines. [↑](#footnote-ref-3)
6. The percent that EHR contributes to the total scare may decrease as use of EHR increases. [↑](#footnote-ref-4)
7. A CMS-approved entity that has self nominated and successfully completed a qualification process to determine whether the entity may collect medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. [↑](#footnote-ref-5)