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MEMORANDUM

June 10, 2016

To: Tribal Health Clients

From: Hobbs, Straus, Dean & Walker LLP

Re: *Comment Deadline Approaching on CMS Proposed Rule to Implement Merit-Based Incentive Payment System and Alternative Payment Model Incentives*

The Centers for Medicare & Medicaid Services (CMS) is accepting comments through June 27, 2016 on its proposed rule, published on May 9, 2016, to establish (1) a new Merit-based Incentive Payment System (MIPS) for eligible clinicians or groups under the physician fee schedule (PFS), and (2) incentives for participation in certain alternative payment models (APMs). Comments on the proposed rule are due by 5:00pm on June 27 and may be submitted at http://www.regulations.gov.

Background

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law on April 16, 2015. Among other things, the MACRA was designed to prevent scheduled decreases in Medicare reimbursement rates under the PFS that were mandated by the Medicare sustainable growth rate (SGR), established by the Balanced Budget Act of 1997. The MACRA repealed the SGR and replaced it with specified annual update percentages. The MACRA also created the MIPS, a new methodology for making value-based payment adjustments to the PFS for eligible clinicians or groups, and created an incentive program to encourage participation in certain APMs.

Merit-Based Incentive Payment System (MIPS)

The MIPS makes substantial changes to the Medicare Part B incentive-based payment program by sunsetting three programs that currently adjust physician payments under the PFS up or down based on performance: (1) the physicians quality reporting system (PQRS), (2) the value based payment modifier (VBPM), and (3) the Medicare Electronic Health Record (EHR) incentive program. The MACRA provides that, beginning in 2019, these three programs will cease to exist as separate programs and will be consolidated under the MIPS. Determinations made under each of these programs, however (i.e., reporting on quality measures, quality of care as compared to cost, and the use of certified EHR technology) will be factors in a provider's MIPS composite performance score, or CPS. By statute, four weighted performance categories are used to determine the CPS: (1) quality, (2) resource use, (3) clinical practice improvement

activities, and (4) advancing care information (similar to EHR).[1] The Secretary is required to develop a methodology to determine a CPS for each eligible clinician based on a one-year performance period and to apply a MIPS adjustment factor based on the CPS. The Secretary is also required to consult with stakeholders in identifying measures and activities for each of the four performance categories, though certain measures and activities are required by statute.

To implement the MIPS program, the proposed rule establishes a new subpart O of CMS regulations at 42 C.F.R. Part 414.1300. As required by the MACRA, for the first two years the proposed rule would define MIPS eligible clinicians to include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups that include those clinicians. In later years, the MACRA permits the Secretary to add new eligible clinicians.[2] The proposed rule would exclude certain Medicare-enrolled practitioners, including newly Medicare-enrolled eligible clinicians in their first year of Medicare participation; Qualifying APM Participants (QPs, discussed further below); certain Partial Qualifying APM Participants; and clinicians that fall under a proposed low-volume threshold.

The rule proposes that the MIPS performance period would be a calendar year, with the first performance period to start January 2017 for the 2019 payment adjustment. As required by the MACRA, the rule also proposes standards for measures, activities, reporting, and data submission (including third-party data submission) for each of the four performance categories, including outcome measures, performance measures, and global population-based measures. Quality measures would be selected annually through a "call for quality measures process" and based on criteria set by CMS to align with CMS priorities, then published in the Federal Register.

The MACRA requires the MIPS to be budget neutral. In the proposed rule, CMS proposes that the MIPS CPS would be compared against a MIPS performance threshold in order to determine whether an eligible clinician receives an upward or downward payment adjustment, or no payment adjustment, and the extent of that adjustment (based on a sliding scale relative to the performance threshold). The performance threshold would be established based on the mean or median of the composite performance scores during a prior performance period. A scaling factor of no more than 3.0 would then be applied to positive adjustment factors to ensure budget neutrality—i.e., to ensure that total upward and downward adjustments are equal. By statute, positive and negative adjustments (before the scaling factor is applied) are limited to the following maximum percentages: 4% in 2019; 5% in 2020; 7% in 2021; and 9% in 2022 and later years. In

[1] CMS proposes that quality will be weighted at 50% in 2019, 45% in 2020, and 30% thereafter; resource use will be weighted at 10% in 2019, 15% in 2020, and 30% thereafter; clinical practice improvement activities will be weighted at 15%; and advancing care information will be weighted at 25%.

[2] Note that MIPS does not apply to hospitals.

addition, for six years beginning in 2019, eligible clinicians with scores above an additional performance threshold would receive an additional positive adjustment factor, for which $500 million has been set aside each year.[3]

The proposed rule also proposes that CMS will provide confidential feedback reports to MIPS eligible clinicians, beginning in 2017 with performance feedback on the quality and resource use performance categories. Initially, the performance feedback would be provided on an annual basis, but CMS notes in the preamble to the proposed rule that it could be provided on a more frequent basis and for additional performance categories in the future. In addition, the proposed rule proposes public reporting of MIPS information through the Physician Compare website.

The MACRA requires the Secretary to provide special guidance and assistance to eligible clinicians in small practices, rural areas, and practices located in geographic health professional shortage areas (HPSAs) with 15 or fewer eligible clinicians. In the proposed rule, CMS proposes to define "rural areas" to include clinicians in counties designated as Micropolitan or Non-Core Based Statistical Areas (CBSAs), using HRSA's 2014-2015 Area Health Resource File.[4] CMS states in the preamble to the proposed rule that it will provide details regarding the technical assistance program in separate guidance.

Alternative Payment Model Incentives

Eligible clinicians can obtain favorable MIPS scoring by participating in an APM, or avoid MIPS payment adjustments altogether by participating in a qualifying "Advanced APM." Under the MACRA, APMs include the following four categories: CMS Innovation Center Models under Section 1115A of the Social Security Act (excluding a health care innovation award); the Shared Savings Program under section 1899 of the Social Security Act; demonstrations under the Health Care Quality Demonstration program (section 1866C of the Social Security Act); and demonstrations required by federal law. Advanced APMs are APMs that meet three additional criteria under the proposed regulations: (1) use certified EHR technology, (2) base payment on quality measures comparable to MIPs, and (3) require APM entities to bear more than a nominal risk for monetary losses, or are a Medical Home Model. Eligible providers participating in Advanced APMs would be considered Qualifying APM Participants (QPs) and would not be subject to MIPS; would receive a lump sum incentive payment (equal to 5% of the estimated aggregate payments for covered professional services

[3] The proposed rule defines this additional performance threshold as a CPS at least equal to the 25th percentile of the range of possible scores above the performance threshold, or the 25th percentile of the actual CPS at or above the performance threshold for the prior period used to determine the performance threshold.

[4] *See* http://datawarehouse.hrsa.gov/data/datadownload/ahrfdownload.aspx.

furnished in the immediately preceding payment year) in the years 2019 through 2024; and would receive a higher fee schedule update for 2026 and beyond. Eligible providers that participate in an APM but are not considered QPs would be subject to MIPS but would receive favorable scoring in the MIPS clinical practice improvement activities performance category.

The proposed rule provides that CMS would notify the public (on the CMS website) of which APMs will be considered Advanced APMs prior to the start of each QP Performance Period. In comments submitted thus far, physicians have raised concerns about the narrow proposed definition of Advanced APMs, noting that many existing alternative payment models will not qualify. The proposed rule also includes a proposed methodology and criteria to implement the MACRA threshold for the level of participation in Advanced APMs that is required for an eligible clinician to be considered a QP for a given year.

The MACRA also created a Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review stakeholder input and provide recommendations to the Secretary on proposed Physician-Focused Payment Models (PFPMs), meaning APMs wherein Medicare is a payer. The proposed rule includes definitions and criteria that would be used by the PTAC, CMS, and the Secretary to evaluate proposals for PFPMs, including value, care coordination, patient safety, patient engagement, and use of information technology.

Conclusion

In the preamble to the proposed rule, CMS frames the MACRA and the proposed regulations as part of a larger effort to transform payment structures to improve quality and patient outcomes and tie payment to value. Thus far, IHS and tribal health programs have not been impacted to the same extent as many other clinicians and practitioners because they typically bill the OMB all-inclusive rate, and reform efforts (including the MACRA and the proposed implementing regulations) have mostly targeted the Physician Fee Schedule. Still, tribal health programs could be impacted in some instances and should be part of the conversation as payment reforms are designed and implemented. In prior comments, the CMS Tribal Technical Advisory Group (TTAG) and the National Indian Health Board (NIHB) requested that CMS engage in tribal consultation regarding implementation of the MACRA. In the preamble to the proposed rule, CMS acknowledged these requests and stated that it intends "to continue open communication with stakeholders (including consultation with tribes and tribal officials) on an ongoing basis[.]" The TTAG Payment Reform Subcommittee is developing a detailed set of comments on the proposed rule, which we are assisting in drafting.

We attach the full text of the proposed rule, as well as a CMS fact sheet.[5] If you have further questions about the proposed rule or if you would like assistance in submitting comments, please contact Elliott Milhollin at (202) 822-8282 or emilhollin@hobbsstraus.com; Geoff Strommer at (503) 242-1745 or gstrommer@hobbsstraus.com; or Caroline Mayhew at (202) 822-8282 or cmayhew@hobbsstraus.com.

[5] These and other resources are also available on the CMS website at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program.html.