Proposed Rule: Medicare Physician Fee Schedule

New Models for Physician Payments: What Suppliers Need to Know – June 2016

The Centers for Medicare and Medicaid Services (CMS) released their proposed rule on April 27, 2016, outlining how new Medicare payment choices for physicians will work. Physicians must soon choose between the two programs created by the Medicare Access and CHIP Reauthorization Act (H.R. 2): the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). This decision impacts how physicians will be reimbursed in 2019. Both tracks aim to tie physician reimbursement rates more closely to quality and efficiency measures with the ultimate goal of improving patient care. The MIPS track streamlines CMS’ current quality program, while APMs go a step further by offering an additional financial incentive to physicians willing to take on higher financial risk and meet higher quality standards. The proposed rule strives to align standards wherever possible between the two tracks in order to allow flexibility for physicians to transition between the two models from year to year.

Key Takeaways from the Proposed Rule:
- The majority of physicians are expected to stay in MIPS
- CMS proposes all physicians start reporting under MIPS on January 1, 2017, during which time APM eligibility would be determined
- 2017 reporting data will impact 2019 payments; physicians need to prepare now
- The Bundled Payments for Care Improvement Initiative and other bundled payment programs will not qualify as APMs under the proposed rule

Outlook: The Landscape Ahead

The final rule and finalized list of quality measures for MIPS reporting is not expected to be released by CMS until late 2016. This leaves physicians as little as two months to understand and interpret the final rule before initial reporting begins in January of 2017. The timing of this release is further complicated by the coming changes in the Administration. New leadership at CMS will want to review any rules released late this year, potentially causing additional delays and possibly shrinking the already narrow implementation window. CMS recommends all physicians report through MIPS in the first year to create a safety net for physicians hoping to qualify as APMs. Reporting provides the fallback option to receive MIPS payment adjustments and avoid a penalty in the case that they fall short of meeting the higher APM participation requirements during the first years of the program. CMS would notify physicians by mid-2018 if they qualify as an APM. Because of the rigorous standards to qualify as an APM, CMS projects only 30,000-90,000 physicians will initially qualify under this model, compared to the 687,000-746,000 physicians expected to initially participate under MIPS. The data reported in 2017 and 2018 will then be used by CMS to set physician payment adjustments for CY 2019.

Implementation Timeline

<table>
<thead>
<tr>
<th>2016-2019</th>
<th>2017</th>
<th>2019</th>
<th>2020-2025</th>
<th>2026 &amp; Beyond</th>
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<tr>
<td>0.5% annual update provides stability for providers</td>
<td>All physicians begin reporting under MIPS</td>
<td>Payment adjustments under MIPS &amp; APMs begin</td>
<td>Frozen payment rate updates w/ bonus opportunities</td>
<td>0.25% annual update for MIPS or 0.75% for APMs</td>
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**Merit-Based Incentive Payment System (MIPS)**

MIPS has consolidated and replaced all of the former Medicare fee-for-service payment quality programs with one value-based performance program. The current programs: Electronic Health Records (EHR) incentive payment program, the Physician Quality Reporting System and the Value-Based Payment Modifier will all sunset (expire) at the end of CY 2018. Under the proposed rule, physicians would be able to cherry pick measures under the four domains in order to account for diversity between specialties. Four basic quality domains would be used to develop a physician’s MIPS score. The proposed rule calls for these scores to be reported annually, though some physician groups have called for quarterly reporting to allow more opportunities for improvement. The four domains to be considered are: Quality, Advancing Care Information, Clinical Practice Improvement, and Cost.

**MIPS Performance Categories**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Weight</th>
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<tbody>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
</tr>
<tr>
<td>Clinical Practice Improvement</td>
<td>15%</td>
</tr>
<tr>
<td>Cost</td>
<td>10%</td>
</tr>
<tr>
<td>Quality</td>
<td>50%</td>
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**Advancing Care Information (25%)**: Physicians would report on a set of customizable measures demonstrating their technology use, with emphases on interoperability and information exchange. Scored out of 100 points.

**Clinical Practice Improvement (15%)**: Physicians choose best measures for their practice from 90+ options. Physicians in medical homes earn full credit, those in APMs will earn at least half credit. Scored out of 60 points.

**Quality (50%)**: Physicians would choose six measures from a list of 200+ to report on. One measure must be an outcome or high quality measure and one must be a crosscutting measure. Scored out of 80-90 points depending on group size.

**Cost (10%)**: This score is based on Medicare claims. This category does not add reporting for physicians. If patient volume is too small, this score is omitted. Scored on an average of all resource measures that can be attributed.

**Penalties**

The resulting MIPS score would be used to determine how much the provider would be paid in comparison to other MIPS providers. Reimbursements are being adjusted into a single, budget-neutral payment. Because the program is budget neutral, the overall negative adjustments would equal the overall positive adjustments. By the year 2022, the range could reach -9% to +27%. The law also allows for an additional $500 million in bonuses to reward exceptional performance, which would be exempt from the budget neutrality requirement. This could allow exceptional performers a gradually increasing adjustment based on their MIPS score of up to an additional 10%.

<table>
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<th>Year</th>
<th>Baseline Payment Adjustment</th>
<th>Maximum Positive Payment Adjustment</th>
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<tbody>
<tr>
<td>2019</td>
<td>-/+ 4%</td>
<td>+ 12%</td>
</tr>
<tr>
<td>2020</td>
<td>-/+ 5%</td>
<td>+ 15%</td>
</tr>
<tr>
<td>2021</td>
<td>-/+ 7%</td>
<td>+ 21%</td>
</tr>
<tr>
<td>2022</td>
<td>-/+ 9%</td>
<td>+ 27%</td>
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Alternative Payment Models (APMs)

APMs offer an incentive for physicians to completely opt out of traditional Medicare fee-for-service payments. Opting into an APM requires accepting financial risk for providing coordinated, high-quality care. Physicians who participate in APMs are excluded from MIPS adjustments, and instead qualify for a 5% per year Medicare Part B incentive payment between the years 2019 and 2024. Beginning in 2026, APM physicians would receive a higher fee schedule update than non-APM physicians. CMS proposes 3 standards to qualify as an APM:

**Financial Risk**
- Total risk: must be at least 4% of the APM spending target
- Marginal risk: must be at least 30%
- Minimum loss rate: no greater than 4%

**Quality Measures**
- Evidence-based
- Reliable
- Valid
- At least one must be an outcome measure if applicable

**Certified EHR Technology**
- At least 50% of clinicians use EHR technology
- Increases to 75% in the second performance year

Physicians can bypass the financial risk category if they belong to an approved medical home model which focuses on primary care and accountability. The participation requirements for APMs would only apply to Medicare Part B payments or patients from 2019 through 2020. However, beginning in 2021, participation requirements could extend to non-Medicare payers and patients. Through “Other Payer Advanced APMs,” physicians may qualify for incentive payments through APMs developed by non-Medicare payers beginning in performance year 2019. Such payers could include private insurers or state Medicaid programs.

**Proposed Qualifying APMs**

CMS identified six APM models in their proposed rule. This list would be updated annually:

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

It is worth noting that under CMS’ proposed rule, the Bundled Payments for Care Improvement (BPCI) Initiative, the Comprehensive Care for Joint Replacement (CJR) Model, and Track 1 Medicare Shared Savings Program ACOs would not qualify as previously anticipated.