Medicare’s Quality Payment Program for Physicians: MIPS and Advanced APMs

The information in this document is based off of policy information available as of October 2016. Updated information may be available at www.qpp.cms.gov.
Summary
The MACRA legislation of 2015 reforms how Medicare pays physicians, encouraging a shift to value-based payments across all providers. MACRA specifically replaces the Sustainable Growth Rate (SGR) as a mechanism to control growth in Medicare spending, with annual 0.5% physician fee schedule payment updates through 2019. Under this law, CMS also implements the Quality Payment Program (QPP), which introduces 2 distinct tracks for physician payment: the Merit-based Incentive Payment System (MIPS) or Advanced Alternative Payment Models (Advanced APMs).

Though both MIPS and Advanced APMs payments will go into effect in 2019, physician practice choices, performance, and reporting from 2017 will be the evaluation period against which 2019 payment path (Advanced APM or MIPS) is designated and payment adjustments are made (MIPS).

The implementation of the QPP is intended to encourage physician movement from the traditional fee-for-service payment system to payment for quality and value, where providers across various sites of services may be held at risk and accountable for the costs and quality of the care provided to patients and patient populations.

2 Quality Payment Program Tracks for Physicians
Begin in 2019

Merit-based Incentive System (MIPS)
- Fee-for-service payments with annual adjustments based on composite performance across several components (defined in MIPS section below)
- Streamlines and replaces existing reporting programs
- Program is budget neutral, so there will be winners and losers.

Advanced Alternative Payment Models
- Sufficient participation in qualifying Advanced APMs, (defined in section below) may exempt physicians from MIPS payment adjustments as participants are at risk for both the quality and costs of care and subject to value-based payment adjustments through these Advanced APMs.
- Financial incentives encourage participation.

Rollout of Payment Updates, Risks, and Rewards under the Quality Payment Program: MIPS and Advanced APMs

<table>
<thead>
<tr>
<th>Physician Fee Schedule Update</th>
<th>Advanced APM Financial Incentives</th>
<th>MIPS Financial Incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5% Fee Schedule Update</td>
<td>0.0% Fee Schedule Update</td>
<td>0.75% annual update, Advanced APM path OR 0.23% annual update, MIPS path</td>
</tr>
</tbody>
</table>

2017 PICK-YOUR-PACE REPORTING
- Full Year
- Partial Year
- "Test" Reporting
- No Reporting

2017 Performance Period for 2019 Payment

<table>
<thead>
<tr>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024</th>
<th>2025</th>
<th>2026+</th>
</tr>
</thead>
<tbody>
<tr>
<td>± MIPS</td>
<td>± 5% MIPS</td>
<td>± 7% MIPS</td>
<td>± 9% MIPS</td>
<td>± 4%/0</td>
<td>± 4%/0</td>
<td>± 4%/0</td>
<td>± 4%/0</td>
</tr>
</tbody>
</table>

5% lump sum bonus payment, participants of qualifying Advanced APMs
### Merit-based Incentive Payment System (MIPS) Details

MIPS consolidates and replaces 3 currently existing programs (Physician Quality Reporting System [PQRS], Value-based Payment Modifier [VBPM], and Meaningful Use) into one composite performance score which is the basis for payment adjustment. As noted by the American Medical Association (AMA), the aggregate level of financial risk to practices from MIPS penalties is less than what they would receive under the current regulations.¹

- Physician composite scores, reported on a 0-100 scale, will be publicly transparent and comparable.
- The MIPS program is proposed to be budget neutral: stronger performers benefit at the expense of those with low scores (or not reporting data).

### 4 Components Determine MIPS Score: 2017 Performance Determines 2019 Payment

Payment adjustments are based upon weighted composite performance. The performance period is 2 years prior to the payment period. 2019 payments will be based upon 2017 performance. Though cost is weighted 0% in the first performance period, physicians will receive feedback on their cost performance to prepare for 30% weighting of this category by the 3rd payment year of the program, 2021. CMS has indicated that cost will be a weighted component of MIPS in performance year 2018, expected to be a "ramp-up" year, prior to the full 30% in the 2019 performance year.

<table>
<thead>
<tr>
<th>2017 Performance</th>
<th>2019 Payment</th>
<th>2021 Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>25% EHR Use</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>15% TBD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60% TBD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30% TBD</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Advancing Care Information
- **EHR Use**

### Clinical Practice Improvement Activities
- **Care coordination, patient engagement, and safety**

### Cost/Resource Use
- Though assigned no weight in 2017, cost will ramp-up to 30% of MIPS score, affecting payments by 2021.
- Total Medicare per capita cost
- Medicare physician spending per beneficiary
- Episode-based cost measures

### Quality
- Physicians choose 4 measures from among 200+ one must be outcome based

### Transition Year: 2017

In order to ease the transition to the QPP and educate physicians and physician practices on the requirements under MIPS and Advanced APMs, CMS has designated 2017 a transitional year. CMS plans to iterate and incrementally evolve the roll-out of the QPP through the next years until full reporting requirements and payment penalties and rewards, as described by the MACRA legislation, are in place. As of the Oct. 14, 2016 Final Rule with Public Comment, the following provisions have been made to ease the transition to the QPP in 2017:

1. Reduced number of reporting requirements within each MIPS performance category. Incremental and iterative increases are anticipated as the program develops.
2. Pick-Your-Pace 2017 Reporting: Clinicians and practices that submit data on at least one reporting measure in each MIPS component will not receive a negative payment adjustment in 2019. (See the “Rollout of Payment Updates, Risks and Rewards” diagram on page 1.)
3. 2017 Costs will not impact 2019 payments: Weighting of the MIPS cost category = 0% in 2017. However, physicians and practices will receive feedback on performance in this category to enable planning for future performance. By payment year 2021, cost weighting will reflect 30% of 2021 MIPS adjustment per statute.
Advanced Alternative Payment Models (APMs) Payment Track Details

Advanced APMs, identified by CMS, are a subset of APMs which meet specific, statutorily defined requirements (e.g., 2-sided risk, payments linked to quality and EHR use). Eligible clinicians with a significant share of volume (revenue or patient count) in Advanced APMs are exempt from MIPS reporting and payment adjustments. This insures the eligible clinicians against double jeopardy, and the Medicare program from double payments, as clinicians sufficiently participating in Advanced APMs are subject to quality and value-linked payments through these programs.

Qualifying Professionals (QPs) and Partially Qualifying Professionals (Partial QPs)

Eligible clinicians and entities participating in Advanced APMs are identified by CMS as either Qualifying Professionals (QPs) or Partially Qualifying Professionals on the basis of the revenue or patient count. The volume of participation determines eligibility for Advanced APM financial incentives.

- While both QPs and Partial QPs are in the Advanced APM payment track, only QPs are eligible for the Advanced APM financial incentives.
- Partial QP entities which would prefer MIPS incentives may opt into the MIPS, under the MIPS APM scoring standard, with favorable recognition of APM participation, whereby all participants in the entity will receive the same MIPS APM composite score.
- Eligible Clinicians participating in APMs that are not designated as Advanced APMs will be in the MIPS payment track.

Annual Advanced APM Participation Thresholds to Qualify for APM Payment Path

<table>
<thead>
<tr>
<th>Payment Year</th>
<th>Revenue/Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>25%/20%</td>
</tr>
<tr>
<td>2020</td>
<td>50%/35%</td>
</tr>
<tr>
<td>2021</td>
<td>75%/50%</td>
</tr>
<tr>
<td>2022</td>
<td>75%/50%</td>
</tr>
<tr>
<td>2023</td>
<td>75%/50%</td>
</tr>
<tr>
<td>2024+</td>
<td>75%/50%</td>
</tr>
</tbody>
</table>

Population of Reference

- Medicare Only
- All Payer Combined

Advanced APMs

As of November 4, 2016, CMS has announced the following models will qualify as Advanced APMs for performance year 2017 (The final list will be released by January 1, 2017. CMS intends to update the list at least annually):

- Comprehensive ESRD Care Models
- Oncology Care Model (2-sided risk)
- Next Generation ACOs
- Comprehensive Primary Care Plus
- Medicare Shared Savings Programs (Tracks 2 & 3)

Key Take-aways

The Oct. 14, 2016 Final Rule on the QPP was released with a public comment period and explicit statement that the implementation of the provisions of the MACRA legislation by CMS will be “iterative.” Expect several updates as the policy continues to evolve.

With clear incentives for provider participation in Advanced APMs, the MACRA legislation and CMS’ proposed implementation make it clear that value-based payments are the future of Medicare payment.

At the same time, traditional fee-for-service payment is the foundational architecture upon which all of the delivery reform models (MIPS, Advanced APMs, Bundled Payments, etc.) are based. Fee-for-service payment schedules remain critical components of documenting, identifying, and defining cost to determine value based payments.

Specific implications from the physician payment reforms within MACRA:

- Physician payment continues to be driven off of the Physician Fee Schedule.
- Meeting the administrative requirements will be a challenge for many physician practices. Small practices may be disproportionately affected by these requirements.
  - Providers with fewer than $30,000 Medicare billed charges, or < 100 Medicare patients, as well as those in their first year accepting Medicare assignment, are excluded from the QPP.
- The opportunity to participate in an Advanced APM may not exist for all physicians, rendering MIPS the only payment option.
- Provider consolidation (horizontal and vertical) may rise to ease the reporting burden and financial exposure, potentially affecting sales channels and customer priorities as business structures evolve.
- Patient engagement is identified in MACRA as a foundational component to successful participation.
Possible Future Developments

The information included in this document is based upon the Final Rule with Public Comment Period dated Oct. 14, 2016, and subsequent CMS announcements through Oct. 25, 2016. Although CMS did release a Final Rule, the rule has an associated public comment period, and final ruling (concurrent with implementation) is scheduled for Jan 1, 2017. Additionally, CMS has stated that it “expects the QPP to evolve over multiple years” and that it plans to use a “staged approach” and an iterative process to full implementation.

- CMS will continue to issue rulings on the QPP as it ramps up requirements for physicians in compliance with MACRA.
- Information in this document reflects interpretation of the October 14 Final Rule with Comment Period and relevant CMS announcements up to November 4, 2016.
- Significant continued development, in collaboration between CMS and key stakeholders, is anticipated to further identify and define payment models qualifying as Advanced APMs.
  - Cardiac and orthopedic joint replacement bundled payments and new, ACO track 1+ models may qualify as Advanced APM models starting in 2018.
- Reduction in lag between the performance period and payment adjustment may be anticipated as the QPP continues to evolve.

Reference


Additional Sources


Department of Health and Human Services Center for Medicare & Medicaid Services 42 CFR Parts 414 and 495. 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. Proposed Rule. May 9, 2016.


The Advisory Board Company. MACRA: What you need to know right away about the proposed rule. May 9, 2016.