Quality Payment Program
Proposed Rule Guide

On April 27, 2016, CMS released a proposed rule on the Quality Payment Program, which includes both the Merit-Based Incentive Payment Program (MIPS) and Advanced Alternative Payment Models (APMs). The proposed rule is CMS’ first attempt to develop regulations on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), signed into law in April 2015, which codifies the new system physicians will be paid under Medicare.

This guide summarizes the Quality Payment Program proposed rule, however, ASCRS will continue to develop more in-depth guides on each of the program elements going forward. ASCRS has 60 days to provide feedback to CMS based on these proposals. A final rule is expected in fall 2016.

MIPS Assessment Categories

MIPS will assess the performance of clinicians based on four categories: Quality, Cost, Advancing Care Information (EHR) and Clinical Practice Improvement Activities.

Quality: 50% of Total Score in Year 1
Clinicians must report a minimum of 6 measures, with at least one cross-cutting measure and one outcome measure, if available. If no outcome measure applies to the clinician, they would report one “high priority measure.” CMS will also use claims data to calculate two or three population measures, depending on the size of the group.

Cost: 10% of Total Score Year 1
Includes two of the cost measures previously used in the Value Based Payment Modifier (VBPM) program: Total Per Capita Costs for all attributed beneficiaries and Medicare Spending per Beneficiary. Episode-based measures will also be used to evaluate cost as applicable. There are ophthalmic procedures included in the proposed episode groups, including cataract surgery.

Advancing Care Information: 25% of Total Score Year 1
This section replaces the EHR Meaningful Use incentive program. It is comprised of a score for participating and reporting (base score) and a score for reporting at various levels above the base score (performance score). Clinicians must submit data for a full calendar year reporting period. The base score makes up 50 points and the performance score makes up 80 points. If clinicians earn 100 points or more, they will earn full credit for the Advancing Care Information category.

Clinical Practice Improvement Activities (CPIAs): 15% of Total Score in Year 1
Clinicians can select activities from a list of more than 90 options, such as care coordination, beneficiary engagement and patient safety. There are two types of activities clinicians can choose from: medium-level activities worth 10 points and high-level activities worth 20 points. CPIAs must be performed for at least 90 days during the reporting period.

Composite Score

Eligible professionals will receive a composite score (0-100) based on their performance in these aforementioned categories. Each eligible professional’s composite score will be compared to a performance threshold, which will be the mean or median of all composite performance scores for all MIPS eligible professionals during a prior period. Weights may be adjusted if there are not sufficient measures and activities applicable for specialty providers, including assigning a scoring weight of 0 for a performance category.
Incentives and Penalties

Eligible professionals will receive a positive, negative, or neutral payment adjustment based on their composite score. The **negative adjustment** will be capped at four percent in 2019, five percent in 2020, seven percent in 2021 and nine percent in 2022. Eligible professionals that fall between zero and one-fourth of the threshold will receive the maximum negative penalty. Providers whose scores are closer to the threshold score will receive smaller negative payment adjustments.

If an eligible professional’s composite score is at the threshold, they will not receive a MIPS payment adjustment. Eligible professionals with composite scores above the threshold will receive **positive payment adjustments**. The higher performance scores will receive proportionally larger incentive payments up to three times the annual cap for negative payment adjustments each year. Positive incentives are increased or decreased by a scaling factor to achieve budget neutrality with the aggregate application of negative adjustments. For six years beginning in 2019, providers can also earn additional incentive payments for “exceptional performance.”

Advanced Alternative Payment Models (APMs)

CMS is encouraging participation in Advanced Alternative Payment Models (APMs). Eligible clinicians who receive a significant share of their revenues or treat a certain percentage of patients through an APM that involves more than nominal risk of financial loss, a quality measure component, and has the majority of participants using Certified Electronic Health Record Technology (CHERT) will receive a **5% bonus for each year from 2019-2024**. Advanced APMs include Accountable Care Organizations with two-sided risk and medical homes.

For 2019, based on performance year 2017, clinicians must derive at least 25% of payment amounts or 20% of patients from an APM to receive the bonus payment. **Clinicians achieving those APM thresholds will be excluded from MIPS requirements. These percentages of payment amounts or patients required to qualify for the APM bonus will increase in future years.**

Other Payer APMs

Other Payer APMs include payment arrangements under any payer other than traditional Medicare, including Medicare Advantage and other Medicare-funded plans. **Beginning in 2021** (performance year 2019), these other payers will count toward APM thresholds. However, the 5% bonus for significantly participating in an Advanced APM will be based on Medicare and will not include Medicare Advantage payments.

Intermediate Options

Advanced APM participants who fall short of requirements for the incentive payments would be able to choose whether they would like to receive a payment adjustment through MIPS. In order to opt out of the MIPS payment adjustment for 2019 and 2020, the clinician must receive 20% of their Medicare payments through an Advanced APM or must see 10% of their Medicare patients through an Advanced APM. They will not qualify for the 5% bonus payment under the APM category.

Additional Resources

For additional information, you may contact Ashley McGlone at amcglone@ascrs.org or 703-591-2220.