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MIPS AND THE ONCOLOGY CARE MODEL

As proposed by CMS, physicians and other MIPS[1] eligible clinicians in physician groups that participate in the Oncology Care Model ("OCM") would be subject to a MIPS scoring methodology different from the scoring methodology applied to most MIPS eligible clinicians, at least during the first year of MIPS. The unique scoring methodology is likely to be included in the final MIPS regulations. Physician groups participating in the OCM may want to weigh how their MIPS eligible clinicians would fare under this scoring methodology and begin considering ways to help ensure that their MIPS eligible clinicians achieve their best possible MIPS scores.

COMPUTING A MIPS COMPOSITE PERFORMANCE SCORE FOR MIPS ELIGIBLE CLINICIANS IN OCM PHYSICIAN GROUPS

CMS proposed to annually compute a composite performance score ("CPS") for all MIPS eligible clinicians (i.e., physicians, physician assistants, nurse practitioners, clinical nurse specialists and CRNAs), including MIPS eligible clinicians in physician groups that participate in the OCM. CMS would compute a CPS based on performance data reported for a "MIPS performance period" (i.e., January 1 through December 31). The first MIPS performance period, as currently proposed by CMS, would be 2017.[2]

CMS would use the CPS computed for a MIPS eligible clinician to determine whether it would adjust (positively, negatively or not at all) the Part B reimbursement for items and services provided by the clinician during a "MIPS payment year." A MIPS payment year is the calendar year that begins one year after the end of a MIPS performance period. CMS currently proposes the first MIPS payment year to be 2019 (which relates to a 2017 MIPS performance period). As proposed for 2019, a MIPS payment adjustment could range from a negative 4 percent adjustment to, in exceptional cases, a positive 14 percent adjustment (subject to certain calculations made to achieve budget neutrality for the total MIPS adjustments for 2019).

As a general rule, for MIPS eligible clinicians in most physician groups not participating in the OCM, CMS would compute their CPS based upon their physician group's scores on all four of the MIPS performance categories: (1) quality; (2) resource use; (3) advancing care information; and (4) clinical practice improvement activities ("CPIA"). However, CMS proposes a different approach for MIPS eligible clinicians in OCM physician groups.

As proposed for the 2017 MIPS performance period, CMS would compute the CPS for MIPS eligible clinicians in OCM physician groups based upon their physician group's scores on only two MIPS performance categories: (1) advancing care information; and (2) CPIA. Moreover, *75 percent* of the CPS computed for MIPS eligible clinicians in OCM physician groups would be based on their group's score on the advancing care information performance category (and the remaining 25 percent based on the group's score on the CPIA performance category). In comparison, for MIPS eligible clinicians in most other physician groups, CMS proposes to base only 25 percent of their CPS on their physician group's score on the advancing care information performance category.

It is important to note that the 2017 CPS computed by CMS for MIPS eligible clinicians in an OCM physician group would only apply to the clinicians identified on the group's "OCM Practitioner List" on December 31, 2017. In this regard, it is also important to note that the OCM Participation Agreement, executed by each OCM physician group, imposes certain requirements regarding when a physician group may add or remove OCM Practitioners to the group's OCM Practitioner List. For MIPS eligible clinicians identified on a physician group's OCM Practitioner List at some point during 2017, but not on December 31, 2017, CMS proposes to compute separate CPSs.[3]

In addition, CMS would base its computation of a 2017 CPS for such MIPS eligible clinicians in an OCM physician group only on performance data reported for the MIPS eligible clinicians identified on the group's OCM Practitioner List as of December 31, 2017. The following is a summary of the process CMS would use to compute the CPS.

> Step One: The OCM physician group would report to CMS the required individual performance data (not group level data), for the 2017 MIPS performance period, for each MIPS eligible clinician identified on the group's OCM Practitioner List as of December 31, 2017. The performance data would pertain to objectives and measures specified by CMS for the advancing care information performance category and, separately, to activities specified by CMS for the CPIA performance category (overviews of the two performance categories are set forth below). The physician group would be required to report this performance data to CMS no later than March 31,

2018.

Step Two: A score on the advancing care information performance category and, separately, a score on the CPIA performance category, would be computed for each MIPS eligible clinician based upon each clinician's individual performance data reported under Step One.

Step Three: The score computed for each MIPS eligible clinician on the advancing care information performance category under Step Two would be aggregated at the group level and then averaged for a mean score. Any MIPS eligible clinician described in Step One who does not submit data for the advancing care information performance category would contribute a score of "zero" to the calculation of the mean score.

Step Four: The score calculated for each MIPS eligible clinician on the CPIA performance category under Step Two would be aggregated at the group level and then averaged for a mean score. Any MIPS eligible clinician described in Step One who does not submit data for the CPIA performance category would contribute a score of "zero" to the calculation of the mean score.

Step Five: CMS would compute one CPS for the physician group based on: (1) the group's mean score for the advancing care information performance category computed under Step Three; and (2) the group's mean score for the CPIA performance category computed under Step Four. However, as indicated earlier in this memorandum, CMS would base 75 percent of the CPS on the physician group's *mean* score for the advancing care information performance category.

Step Six: The CPS computed under Step Five would serve as the CPS for *each* MIPS eligible clinician in the physician group identified on the group's OCM Practitioner List as of December 31, 2017 and would be used in determining (by comparison with the CPSs computed for all MIPS eligible clinicians throughout the country) what adjustment (positive, negative or no adjustment) would be applied to the Part B reimbursement paid for items and services provided by each such clinician in 2019.[4]

THE ADVANCING CARE INFORMATION PERFORMANCE CATEGORY

A MIPS eligible clinician's score on the advancing care information performance category (see Step Two in part A above) would be expressed as a percentage and would be composed of a "base score" and a "performance score." To earn points toward the base score, the performance data reported for the clinician would state the numerator and denominator (or yes/no statement as applicable) for certain measures adopted in the 2015 EHR Incentive Program final rule (except that for measures in the final rule that included a percentage-based threshold, CMS would not require that those thresholds be satisfied for purposes of MIPS). The particular measures required to be reported for the clinician would depend upon the certified EHR technology used by the clinician. As proposed by CMS for 2017, MIPS eligible clinicians would be able to use EHR technology certified to either the 2014 or 2015 Edition of EHR certification criteria[5] as follows:

- 2015 Edition. MIPS eligible clinicians using only technology certified up to the 2015 Edition may choose to report: (1) on the objectives and measures specified for the advancing care information performance category (which are set forth in the preamble to the proposed regulations) that correlate to Stage 3 meaningful use requirements of the EHR Incentive Program; or (2) on the alternate objectives and measures specified for the advancing care information performance category (also set forth in the preamble to the proposed regulations) that correlate to modified Stage 2 meaningful use requirements.
- 2014 or 2015 Edition. MIPS eligible clinicians using technology certified to a combination of the 2015 Edition and 2014 Edition may choose to report: (1) the above-referenced objectives and measures specified for the advancing care information performance category that correlate to Stage 3 meaningful use requirements; or (2) the above-referenced alternate objectives and measures specified for the advancing care information performance category that correlate to modified Stage 2 meaningful use requirements, if they have the appropriate mix of technologies to support each measure selected.
- 2014 Edition. MIPS eligible clinicians using only technology certified up to the 2014 Edition would not be able to report on any of the above-referenced measures specified for the advancing care information performance category that correlate to a Stage 3 measure that requires the support of technology certified up to the 2015 Edition. Consequently, CMS proposes to require such clinicians to report on the above-mentioned alternate objectives and measures specified for the advancing care information performance category that correlate to modified Stage 2 meaningful use requirements.

The successful reporting[6] of these objectives and measures would achieve 50 percent of a MIPS eligible clinician's total score on the advancing care information performance category.

After a MIPS eligible clinician's base score is determined, CMS would calculate the clinician's performance score. The performance score would be based on a performance in certain Stage 3 or modified Stage 2 (as applicable) objectives and measures for: (1) Patient Electronic Access; (2) Coordination of Care through Patient Engagement; and (3) Health Information Exchange. The combination of the performance score and the base score (plus, if applicable, a bonus point for reporting on certain immunization-related measures) would constitute the clinician's total score on the advancing care information performance category.

CMS proposes to allow OCM physician groups to forgo reporting performance data on the advancing care information performance category (see Step One in part A above) for certain MIPS eligible clinicians. For example, for the 2017 MIPS performance period, CMS would permit a physician group to elect not to report such performance data for a physician assistant, nurse practitioner, clinical nurse specialist or CRNA. In addition, although the legislation that enacted MIPS did not include the "significant hardship" exceptions currently available under the EHR Incentive Program, CMS proposes to replicate those same exceptions under MIPS (for example, a physician group could forgo reporting the performance data for a MIPS eligible clinician if the group successfully demonstrates to CMS that one or more measures in the advancing care information performance category was "not applicable" and/or "unavailable" to the clinician for reasons outside of the group's control). Furthermore, CMS would excuse physician groups from reporting the performance data for MIPS eligible clinicians who are "non-patient facing" (e.g., interventional radiologists and nuclear medicine physicians).

The calculation of an OCM physician group's mean score on the advancing care information performance category (see Step Three in part A above) would be affected whenever CMS permits the group to forgo reporting such performance data for one or more of the group's MIPS eligible clinicians. In addition, in the event an OCM physician group is permitted to forgo reporting performance data on the advancing care information performance category for a MIPS eligible clinician in the group, it is possible that the clinician would become automatically ineligible for any payment adjustment (positive or negative) during the MIPS payment year, regardless of the CPS otherwise calculated by CMS.[7]

THE CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY

As noted earlier, for the 2017 CPS computed for MIPS eligible clinicians in OCM physician groups, CMS proposes to base 25 percent of the CPS on the CPIA performance category. The CPIA performance category involves activities that are designed to improve clinical practice and/or care delivery and, in the view of the Secretary of HHS, are likely to result in improved outcomes. The appendix to the proposed MIPS regulations includes a list of the activities proposed for this performance category. The activities are grouped under eight subcategories: (1) Expanded Practice Access; (2) Population Management; (3) Care Coordination; (4) Beneficiary Engagement; (5) Patient Safety and Practice Assessment; (6) Achieving Health Equity; (7) Emergency Response and Preparedness; and (8) Integrated Behavioral and Mental Health.

The maximum number of points a MIPS eligible clinician may earn under the CPIA performance category is 60. A MIPS eligible clinician's score under the CPIA performance category (see Step Two in part A above) is expressed as a percentage, with the highest potential score of 100 percent being achieved by scoring 60 points. CMS would automatically assign 30 points (i.e., 50 percent of the total points available) for a performance period to a MIPS eligible clinician in a physician group that participates in the OCM.[8] The clinician would be able to earn the remaining 30 points by engaging, for at least 90 days during the performance period, in two or more of the CPIA activities (depending on the points scored for the activities) included under one or more of the above-referenced eight subcategories. Some of the CPIA activities are scored at 10 points, the others are scored at 20 points.[9]

PRACTICAL TAKEAWAYS

OCM physician groups should begin to familiarize themselves with the measures proposed for the advancing care information performance category and the activities proposed for the CPIA performance category. Because CMS conducted an unusually extensive amount of research prior to publishing the proposed regulations, including its receipt of stakeholder input via a Request for Information, it is reasonable to suspect that CMS's final MIPS regulations will not substantially change such measures or activities.

The 2019 MIPS payment adjustment to the Part B reimbursement for items and services provided by a MIPS eligible clinician in an OCM physician group, based on the 2017 MIPS performance period, could be substantial. As noted earlier in this memorandum, such adjustment could vary between a negative 4 percent adjustment to, in exceptional circumstances, a positive 14 percent adjustment. Given the financial

consequences that will result from the 2017 CPS computed for an OCM physician group's MIPS eligible clinicians, OCM physician groups should also begin to consider how they might properly incentivize their MIPS eligible clinicians to achieve their best possible MIPS scores for 2017.

Performance-based compensation is a viable tool to help OCM physician groups align the clinical and financial interests of their MIPS eligible clinicians and, in so doing, increase the opportunities for such clinicians to perform successfully under MIPS. Of course, safeguards must be followed (MIPS does not include any waivers or limitations of the federal fraud and abuse laws). Among other things, the performance compensation must reflect fair market value and must not include patient volume. The compensation formula should not encourage MIPS eligible clinicians to skimp on providing necessary care to patients, and the formula should encourage improvement, not reward the *status quo*. With this in mind, a well-crafted formula that is tailored to the applicable measures of the advancing care information performance category and the activities of the CPIA performance category could help ensure positive clinical and financial results under MIPS.

If you have any questions on this topic, please contact Tim Kennedy at (317) 977-1436 or tkennedy@hallrender.com or your regular Hall Render attorney.

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[1] "MIPS" is the "Merit-Based Incentive Payment System" enacted as part of the "Medicare Access and CHIP Reauthorization Act of 2015" ("MACRA").

[2] During recent congressional testimony, CMS Acting Administrator, Andy Slavitt, advised that CMS might delay the MIPS start date, currently scheduled for January 1, 2017. Whether CMS will actually delay the start date (and how long it will be delayed) and whether a delay will apply to all MIPS eligible clinicians (or only to smaller practices) are open questions. Although acknowledging this uncertainty, this memorandum nevertheless refers to a January 1, 2017 start date for MIPS. Regardless of when MIPS may start, the proposed regulations make clear that CMS intends to apply a unique MIPS scoring methodology to IPS eligible clinicians in OCM physician groups, at least for the first year of MIPS' implementation.

[3] Special rules would apply in the event a MIPS eligible clinician has assigned his/her Medicare billing rights to multiple TINS during 2017. Also, in the event a MIPS eligible clinician in an OCM physician group leaves the group after 2017 and reassigns his/her Medicare billing rights to the TIN of another group during 2019, CMS would use the 2017 CPS computed for the clinician when he/she was in the previous group to apply the 2019 payment adjustment for the clinician in the other group (even if the other group is not participating in the OCM).

[4] As proposed, a MIPS eligible clinician in a physician group participating in the OCM under the "two-sided" risk arrangement (at which time the OCM would be considered an "Advanced Alternative Payment Model") may be exempt from a MIPS payment adjustment if the clinician qualifies as a "Qualifying APM Participant" ("QP") or, under certain circumstances, if the clinician qualifies as a "Partial Qualifying APM Participant" ("Partial QP"). Furthermore, a MIPS eligible clinician who obtains QP status would earn a lump sum "APM Incentive Payment." Qualification as a QP or Partial QP would require that the clinician satisfy certain Part B payment or patient count thresholds. Parenthetically, it should be noted that an OCM physician group may not participate in the OCM's two-sided risk arrangement until July 1, 2018.

[5] Beginning with the 2018 performance period, MIPS eligible clinicians would be limited to using only technology certified to the 2015 Edition.

[6] For the 2017 MIPS performance period, "successful" reporting would occur when a numerator of at least "1" is reported for each measure that is required to be reported as a numerator/denominator and a "yes" statement is reported for each measure required to be reported as a yes/no statement.

[7] The proposed regulations clearly provide that, in the case of a MIPS eligible clinician in a physician group that is *not* participating in a MIPS alternative payment model (the OCM is a type of MIPS alternative payment model) and for whom performance data on only one MIPS performance category is reported, such clinician would be automatically designated by CMS to receive no MIPS payment adjustment for the applicable MIPS payment year. If this rule also applies to MIPS eligible clinicians in physician groups that participate in the OCM (the

proposed regulations are not clear on this point, but there is reason to believe that the rule would apply), then whenever an OCM physician group is permitted to forgo reporting performance data on the advancing care information performance category for one of the group's MIPS eligible clinicians, then such clinician, apparently, would be automatically designated by CMS to receive no MIPS payment adjustment for the applicable MIPS payment year (because performance data for only one MIPS performance category, CPIA, would be reported for the clinician).

[8] CMS would automatically assign 60 points (i.e., 100 percent of the total points available) to MIPS eligible clinicians in an OCM physician group that is certified as a "patient-centered" specialty practice, as determined by the Secretary of HHS.

[9] The proposed regulations do not squarely address whether, or how, the "automatic" 30 points would apply to, among others, "non-patient facing" MIPS eligible clinicians (e.g., interventional radiologists and nuclear medicine physicians) in OCM physician groups. As background, it should be noted that CMS proposes a special CPIA scoring rule for non-patient facing MIPS eligible clinicians in physician groups that do *not* participate in the OCM or any other MIPS alternative payment model. Under this special scoring rule, such non-patient facing clinicians would receive 30 points (i.e., a score of 50 percent for the CPIA performance category) for engaging in *any* single CPIA activity (regardless of the points actually assigned to the activity) and 60 points (i.e., a score of 100 percent) for engaging in any two CPIA activities (regardless of the points actually assigned to the activities). Significantly, it appears possible under the proposed regulations that this special scoring rule would also apply to non-patient facing MIPS eligible clinicians in physicians groups that participate in the OCM, even though such clinicians would apparently also receive the automatic 30 points just through their physician groups' participation in the OCM. In sum, the application of this special scoring rule (whereby non-patient facing MIPS eligible clinicians would receive a CPIA score of 50 percent or 100 percent simply by engaging in any one or two CPIA activities) to non-patient facing MIPS eligible clinicians who automatically receive 30 points by virtue of their groups' participation in the OCM is unclear under the proposed regulations.