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CMS Issues Final Rule Implementing MACRA

On November 4, 2016, after input from over 100,000 physicians and stakeholders,[1] the *Centers for Medicare and Medicaid Services* (CMS) issued a final rule to implement the *Medicare Quality Payment Program* (QPP) required by the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), with an effective date of January 1, 2017.[2] As mentioned in the May 2016 *Health Capital Topics* article entitled, "*CMS Issues MACRA Proposed Rule One Year After Passage*," Congress passed MACRA, in part, to abolish the *sustainable growth rate* (SGR) physician reimbursement methodology, as well as to implement *value-based reimbursement* (VBR) programs.[3] CMS estimates that approximately 600,000 physicians and clinicians will be subject to the new payment programs under MACRA;[4] consequently, the payment reforms finalized under the rule may impact reimbursement for a large number of U.S. physicians. This *Health Capital Topics* article will discuss the key considerations of the legislation, as well as direct providers to resources that will help them maximize their practice's reimbursement potential through the implementation of these MACRA quality standards.[5]

The MACRA final rule replaced the SGR fee schedule with two programs: the *Merit-based Incentive Payment System* (MIPS) and *Advanced Alternative Payment Models* (Advanced APMs).[6] The intention of the new programs is to institute a payment scheme that will incentivize providers to provide higher quality care at a lower cost.[7] These two payment programs create a feedback mechanism between providers and CMS to trigger reimbursement adjustments based on the achievement of certain quality and cost metrics.[8] In 2017, eligible clinicians may elect to participate in one of three options to utilize and submit data to MIPS, or choose a fourth option to join Advanced APMs.[9]

The MIPS program aims to simplify the reporting process whereby physicians provide data to CMS based on the quality of patient care, and thus ease the administrative burden for physicians by consolidating three current programs for providers enrolled in Medicare:

(1) The *Physician Quality Reporting System* (PQRS);
(2) The *Physician Value-Based Payment Modifier* (PVBM); and,
(3) The *Medicare Electronic Health Record* (EHR) *Incentive Program for Eligible Professionals* (EPs).[10]

Starting in 2017, three performance categories will determine MIPS payment adjustments:

(1) *Quality* (through six physician-selected clinical quality measures), which replaces the PQRS;
(2) *Improvement activities*, i.e., activities that physicians perform to improve their clinical practice (up to four for a minimum of 90 days); and,
(3) *Advancing care information* (i.e., whether *certified electronic health record technology* [CEHRT] is used meaningfully to advance care information), which replaces the Medicare EHR Incentive Program.[11]

In 2018, CMS will consider publicly reporting cost (i.e., *resource use*) data under MIPS.[12] This will be calculated by CMS from adjudicated claims, in contrast to the other three categories, which require physicians to report data to CMS.[13]

Clinicians who opt to participate in the MIPS program are subject to payment adjustments based on their performance on the quality metrics in each of the three aforementioned performance categories.[14] Adjustment eligibility will start at up to four percent in 2019 and continue to grow to up to nine percent by 2022, and will be based on evidence-based and practice-specific quality data linked to physician performance.[15]

MIPS data can be reported individually or as a group with a common Tax Identification Number. Groups must register with CMS by June 30, 2017, in order to be eligible to report pooled MIPS data.[16]

Alternatively, MIPS-eligible clinicians may choose to participate in Advanced APMs to receive incentive payments for assuming additional risk related to patient outcomes.[17] In order to qualify for the five percent incentive in 2019 to 2024, as well as for the exemption from MIPS reporting requirements and adjustments, clinicians must receive 25% of total payments and treat 20% of total patients through Medicare patients participating in an Advanced APM during the transition year of 2017. The percentage requirements for participation will continue to increase up to 75% and 50%, respectively, in 2022 and later.[18]

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There are currently seven identified Advanced APM opportunities:

(1) The Comprehensive *End Stage Renal Disease* (ESRD) *Large Dialysis Organization* (LDO) Care Model;
(2) The Comprehensive ESRD non-LDO Care Model;
(3) *Comprehensive Primary Care* (CPC) Plus;
(4) Medicare Shared Savings Program *Accountable Care Organizations* (ACOs) Track 2;
(5) Medicare Shared Savings Program ACO Track 3;
(6) The Next Generation ACO Model; and,
(7) The *Oncology Care Model* (OCM).[19]

The final rule also established the *Physician-Focused Payment Model Technical Advisory Committee* (PTAC) for ongoing development of APMs.[20] The PTAC consists of eleven appointed experts in *Physician-Focused Payment Models* (PFPMs) who serve three-year terms.[21] Notably, PTAC may approve additional APMs that could be available for providers to utilize under MACRA in the future.

Physicians who wish to participate in traditional Medicare may find more value in participating in the MIPS program, which would allow them to earn a performance-based payment adjustment.[22] Alternately, physicians may choose the Advanced APM program to earn an incentive payment through Medicare Part B for participating in an innovative payment model.[23]

According to CMS, 2017 serves as the transition year for providers to adapt to the new legislation at their own pace. The first year for performance data reporting will be 2017, the reporting deadline is March 31, 2018,[24] and 2019 will be the first payment year.[25] The transition options—also known as "*pick your pace*"—outlined in the final rule are more flexible than initially proposed.[26] Most providers have five options through which to transition to QPP and receive adjustments to all Medicare payments:

(1) Report MIPS data for at least 90-days to potentially qualify for a small positive payment adjustment;
(2) Submit complete 2017 MIPS data to CMS to qualify for a positive payment adjustment;[27]
(3) Report some 2017 MIPS data to avoid the four percent negative adjustment for non-compliance;
(4) Do not report 2017 MIPS data and receive a four percent negative adjustment; or,
(5) Participate in Advanced APMs and potentially qualify for a five percent incentive payment.[28]

The magnitude of potential MIPS-related payment adjustments is dependent on the quantity of data provided and the qualitative performance quality results. When MACRA was approved, the maximum negative adjustment was 11%.[29] The final rule not only mitigates this potential loss due to poor performance by decreasing the potential negative payment adjustment, but provides more opportunities for positive adjustments.[30]

To prevent smaller practices (defined as having $30,000 or less in annual Medicare Part B allowed charges or 100 or less Medicare patients) from becoming disproportionately burdened by the new reporting requirements, the final rule contains specific provisions related to transition support for small practices. Notably, *small practices* are exempt from the new requirements under MACRA for 2017.[31] The low-volume dollar threshold is higher than the $10,000 limit initially proposed, excluding more small practices from potential penalties in 2017.[32]

It may be prudent for providers to consider their transition strategy to the new MACRA requirements in order to minimize possible penalties and negative payments and maximize potential incentive payments as a result of CMS' final rule to implement MACRA legislation.

Resources are available for practitioners during this transition. CMS instituted the *Transforming Clinical Practice Initiative* (TCPI) to assist with developing and adapting quality improvement strategies.[33] Further, the *American Medical Association* provides a *Payment Model Evaluator* tool to determine whether the MIPS or Advanced APM track is right for a particular practice as well as resources for implementation strategies.[34]

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