MACRA Overview and Final Rule Summary

On October 14, 2016, CMS published the final rule associated with the implementation of MACRA: Medicare Access & CHIP Reauthorization Act of 2015. The final rule was based on feedback from over 100,000 stakeholders who provided written comments and attended various outreach sessions. MACRA will eliminate the sustainable growth formula and replace it with a .5% annual rate increase through 2019, after which physicians will be required to shift to one of two Quality Payment Programs: 1) Merit-Based Incentive Payment System (MIPS) or 2): Advanced Alternative Payment Models (Advanced APMs).

Background:

Today the Medicare program covers about 55 million people and expenditures are projected to grow at a rate of 6% for the next decade, largely driven by a growing and aging population. This payment reform will significantly impact cardiology as the average cardiovascular group's payer mix is represented by >65% Medicare. Additionally, as we enter 2017, the national rate of cardiologist integration into hospital system employment has reached nearly 70%.

As hospitals grapple with declining admissions, decreasing disproportionate share payments, payment penalties and mandatory bundled payments, which will likely be implemented in 2017, they now must additionally focus resources on new reporting requirements and engage in various types of activities in order to avoid penalties associated with the professional fees generated by the large physician pools they employ.

It is important to note that a significant percentage of physicians across the country still do not know what MACRA is, nor do they understand how it will directly impact their Medicare revenues. Until last week, many physicians still believed MACRA implementation would be delayed. While the final MACRA regulation will significantly limit the risk of penalties by greatly reducing the requirements in the transition year (2017), not participating and providing no information will still result in up to a -4% payment adjustment in 2019.

Summary of the MACRA Rule:

This rule introduced the concept of a Quality Payment Program (QPP), which is intended to reward the delivery of high-quality patient care through two distinct programs; again it is important to note that providers must actively choose which payment avenue they will pursue:

- Advanced Alternative Payment Models (Advanced APMs)
- Merit-based Incentive Payment System (MIPS) for eligible clinicians or groups under the PFS

The QPP will go into effect January 1, 2017. The transition year 2017 represents a performance period, which will be utilized to determine payment adjustments beginning in 2019. The three existing quality programs, including PQRS, Value Modifier and the Medicare EHR Incentive program, will continue through 2018, at which time they will be sunsetted. Aspects of each program have been incorporated into the QPP for simplicity.

MedAxiom Perspective:

This final rule continues CMS's directive to move towards fee-for-value payment models. To no one's surprise, there were a substantial number of comments from various stakeholders, and we are generally pleased how CMS responded to these comments based on the final rule. In particular, allowing more time for implementation before the full impact of the

QPP will be rolled out allows affected parties to adjust based on what best fits their particular situation. CMS utilizing 2017 as a transition year allows for a more realistic adoption of the QPP, and the threshold for eligible clinicians to avoid a negative payment adjustment in 2019 appears attainable. Clearly, that threshold will increase over time, but the slower approach CMS is taking should make the transition go more smoothly. We will continue to analyze the final rule in more detail and provide more updates as warranted.

Approximately 600,000 clinicians are expected to be affected by MACRA in 2017. The law increased the low-volume threshold to $30,000 in Medicare Part B charges, or 100 Medicare patients. CMS stated that 380,000 clinicians could be exempt from the MIPS program, initially limiting the impact on small group practices. CMS also expects 25% of physicians to participate in advanced APMs in 2018, but for the first year expects about 100,000 to participate.

The summary below is meant to provide a high-level overview of the parameters of the rule, additional details will follow as further analysis is required on the 2,398-page rule published by CMS.

Summary of the Major Provisions

CMS finalized transitional policies, focusing the QPP in its initial years on participation and education.

✓ Advanced Alternative Payment Models (APMs)

Requirements

- Participants must use CEHRT
- Provide payment for covered services based on quality measures
- Participating entities must bear sufficient monetary risk, or be a Medical Home Model
- CMS will complete an initial set of Advanced APM determinations by Jan 1, 2017

✓ Qualifying APM Participants (QPs)

- Eligible clinicians who have a certain percentage of patients or payments through an Advanced APM
- Excluded from MIPS and receive a 5% incentive payment for a year beginning in 2019-2024

✓ Merit-Based Incentive Program (MIPS)

Includes:

Physicians, PAs, NPs, CNs, CRNAs, and groups that include such clinicians who bill under Medicare Part B

Participants

- CMS estimates that more than half of clinicians (~750,000) billing under Medicare PFS will be excluded from MIPS
- Low volume – clinicians with less than $30,000 in allowed Medicare charges or ≤ 100 Medicare patients
- 3 Clinicians qualifying as QPs under Advanced APMs

Performance period of 2017 will determine payment adjustments in 2019

✓ MIPS Measurement Categories and Requirements for Full Participation

Quality

- Quality measures will be selected annually through rulemaking
- Must report at least six (6) quality measures including one (1) outcome measure, or report one (1) specialty-specific measure set
- Each quality measure is worth 10 points
- Each quality measure will receive 3-10 points based on the level of performance
- Maximum total = 60 points

Improvement Activities

- Report the following number of activities:
- Two (2) high-weighted or four (4) medium-weighted activities
- Small practices may report one (1) high-weighted or two (2) medium-weighted activities
- Maximum total = 40 points

Advancing Care Information

- Report on five (5) required measures – all others are optional
- Reporting on all five (5) required measures earns the eligible clinician 50%, and reporting optional measures allows for a higher score
- Bonus points are awarded in 2017 for activities that utilize CEHRT and for reporting to a public health or clinical data registry
- Maximum total = 0-100%

Cost

- For 2017, the weighting of this category is 0%
- CMS will provide feedback on certain cost measures for informational purposes
- Starting in 2018, cost will increase from 0 to 30% by the third MIPS payment year (2021)

Scoring

- For 2017, the first three categories will be aggregated into a final score
- Weighting of each category for the transition year (2017):
  - Quality – 60%
  - Improvement Activities – 15%
  - Advancing Care Information – 25%
  - Cost – 0%
- Threshold to avoid a penalty is three (3) points

Final Score Points	MIPS Adjustment
0 - 0.75	Negative 4% (CMS anticipates that this range will comprise mostly of MIPS eligible clinicians with a final score of 0)
0.76 - 2.9	Greater than negative 4%, but less than 0% (CMS anticipates very few MIPS eligible clinicians to fall in this range)
3.0	0% MIPS adjustment
3.1 – 69.9	Positive MIPS adjustment ranging from 0.1%-4%
70.0 - 100	Positive MIPS adjustment ranging from 0.1%-4% AND an additional MIPS payment adjustment for exceptional performance

Estimated Financial Impact

- Eligible clinicians to participate in MIPS in 2017: ~592,000-642,000
- Estimated MIPS payment adjustments in 2019: $398 million (must be budget neutral, so $199 million in positive and $199 in negative adjustments)
- Additional $500 million available for exceptional performance payments for eligible clinicians with a score ≥ 70

✓ Options for Clinician Participation in the QPP for CY 2017:

Full MIPS Participation

- Report to MIPS for a full 90-day period (ideally for the full year) and report on Quality, Improvement Activities and Advancing Care Information
- This will maximize the clinician's chance to qualify for a positive MIPS adjustment and to qualify for an additional positive adjustment for each year in the first six (6) years of the QPP

Partial MIPS Participation

- Report to MIPS for a full 90-day period (ideally for the full year), and report more than one (1) quality measure, more than one (1) improvement activity, or more than the required measures in the advancing care information category
- This will avoid a negative MIPS adjustment and possibly receive a positive adjustment

Minimum MIPS Participation

- Report one (1) quality measure, (1) one improvement activity or report the required measure of the advancing care information performance category and avoid a negative MIPS adjustment

No MIPS Participation

- If clinicians choose to not report even one (1) measure or activity, they will receive the full negative 4% adjustment

Qualify for MIPS exclusion by meeting the necessary criteria in participating in Advanced APMs

- Clinicians in this category receive a 5% incentive payment

MIPS Eligible Clinician - Solo Practitioner Reports One Measure/Activity in Each Performance Category

Caregory	Possible Score	Weighting	Reported	Actual Score	Weighted	Calculated Score
Quality Measures	60 (10 for each measure)	60%	1 measure, (Low)	3	3 / 60 x 60%	3
Improvement Activities	40	15%	1 (Medium)	20	20/ 40 x 15%	7.5
Advance Care Measures	100%	25%	Required base elements	50%	50% x 25%	12.5
Total						**23**

Result: Above threshold - Positive MIPS Adjustment

MIPS Eligible Clinician – Solo Practitioner reports only one quality measure

Caregory	Possible Score	Weighting	Reported	Actual Score	Weighted	Calculated Score
Quality Measures	60 (10 for each measure)	60%	1 measure, (Low)	3	3 / 60 x 60%	3
Improvement Activities	40	15%	None	0	0 x 15%	0
Advance Care Measures	100%	25%	None	0	0 x 35%	0
Total						**3**

Result: Above threshold - Positive MIPS Adjustment

MIPS Eligible Clinician – Solo Practitioner Reports on all Quality Measures and Two Medium-Weighted Improvement Activities

Caregory	Possible Score	Weighting	Reported	Actual Score	Weighted	Calculated Score
Quality Measures	60 (10 for each measure)	60%	5 measurs, (High) 1 measure, (Medium)	56	56 / 60 x 60%	56
Improvement Activities	40	15%	Two (Medium)	40	40/40 x 15%	15
Advance Care Measures	100%	25%	None	0	0 x 35%	0
Total						**71**

Result: Above threshold - Positive MIPS Adjustment + Exceptional Adjustment