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CMS Finalizes MACRA Rule and Continues Transition Toward Value-based Payments

On October 14, 2016, the Centers for Medicare and Medicaid Services (CMS) released a final rule with comment period (Final Rule) implementing the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Final Rule overhauls the methodology by which most physicians and certain other clinicians participating in Medicare will be reimbursed and marks a significant shift away from fee-for-service payments and toward value-based reimbursement. It also repeals the Medicare Sustainable Growth Rate and provides for winding down, by the end of 2018, the Physician Quality Reporting System (PQRS), the Medicare Electronic Health Record Incentive Program for Eligible Professionals (commonly known as Meaningful Use), and the Physician Value-Based Payment Modifier (VM). In their place, CMS created the Quality Payment Program (QPP), which incorporates components of these programs and creates positive and negative payment adjustments based on reporting and performance metrics. The QPP is effective January 1, 2017, with the first payment adjustments becoming effective in 2019.

QUALITY PAYMENT PROGRAM OVERVIEW

The QPP creates two pathways for payment for eligible clinicians—the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (Advanced APMs). With limited exception, "eligible clinicians" are required to participate in the QPP. Eligible clinicians include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups that include such professionals who bill under Medicare Part B. Eligible clinicians (individually or as a group) who have less than or equal to $30,000 in Part B allowed charges or who care for fewer than 100 Part B-enrolled Medicare beneficiaries in a performance year (collectively, the Low-Volume Threshold) are not required to participate in the QPP, as are newly enrolled Medicare Providers.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Under MIPS, eligible clinicians will receive positive, neutral, or negative payment adjustments based on their reporting and performance of measures in categories such as cost, quality, improvement activities, and use of certified electronic health record technology (CEHRT), which is referred to in the Final Rule as advancing care information (ACI). Eligible clinicians can report individually or as part of a group, defined as a single taxpayer identification number (TIN) associated with two eligible clinicians, one of whom is a MIPS-eligible clinician, who have assigned their billing rights to the TIN.

CMS has designated 2017 as a transition year and left open the possibility that this will extend into 2018. During the transition year, eligible clinicians are required to report on three categories of measures—quality, ACI, and improvement activities. MIPS data must be submitted to CMS by March 31, 2018. After the transition period, eligible clinicians will be required to report on a fourth category, cost of care. Performance in each category is weighted, and each eligible clinician (or group) will earn an overall score based on the weighted performance in all categories. In 2017, quality will be weighted at 60 percent, ACI at 25 percent, and improvement at 15 percent. This overall score will dictate whether the eligible clinician (or group) receives a payment adjustment—either positive, neutral, or, after the transition year, negative. CMS will annually publish the MIPS quality measures that will be used for the following performance year, which it will select with input from providers and other stakeholders.

CMS's exclusion of cost from the transition year will come as welcome news to eligible clinicians; however, CMS will gradually phase in the cost category, which will increase to 30 percent of the overall score by payment year 2021.

The first payment adjustments will occur in 2019 and will be based on performance in 2017. For eligible clinicians participating in MIPS, the maximum payment adjustments (positive and negative) will be 4 percent. This percentage will increase annually to a maximum of 9 percent in 2022.

Eligible clinicians that choose to participate in MIPS in 2017 will have three options:

1. Report a minimum of one quality measure, one improvement activity measure, or all five required ACI measures to avoid a negative 2019 payment adjustment

2. Report measures for at least 90 continuous days, which will qualify the eligible clinician for potentially receiving a small positive payment adjustment. Eligible clinicians that choose this option must report six quality measures (or one specialty-specific measure set), four improvement activity measures, and five ACI measures.

3. Report the measures required for the second option for a full year. Eligible clinicians that choose this third option are eligible to receive the full 4 percent positive payment adjustment.

Eligible clinicians that choose not to participate in MIPS and do not participate in an Advanced APM will receive a downward payment adjustment of 4 percent in 2019.

ADVANCED APMs

As an alternative to the MIPS model, eligible clinicians may participate in the Advanced APM model, which allows eligible clinicians to receive positive payment adjustments for participating in certain risk-bearing payment models. In 2017, eligible clinicians who receive 25 percent of their Medicare payments or see 20 percent of their Medicare patients through an Advanced APM will receive a 5 percent positive payment adjustment in 2019. The threshold percentages for receiving an incentive payment will eventually increase to 75 percent of Medicare payments and 50 percent of Medicare patients. To qualify as an Advanced APM, the payment model must (1) require use of CEHRT, (2) include a payment mechanism based on quality measures similar to those outlined in MIPS, and (3) require participants to bear more than a nominal amount of risk or be a medical home.

CMS will finalize its list of Advanced APMs by January 1, 2017, and the list will likely include Tracks 2 and 3 of the Medicare Shared Savings Program (MSSP), the Next Generation ACO Model, the Comprehensive Primary Care Plus Model, the Comprehensive End-Stage Renal Disease Care Model, and the Comprehensive Care for Joint Replacement Model. MSSP Track 1 ACOs will not be Advanced APMs; however, eligible clinicians participating in Track 1 ACOs will not have any

additional reporting obligations to satisfy the quality reporting requirements under the MIPS.

In the Final Rule, CMS also mentioned that it is developing a Medicare ACO Track 1 Plus Model that will likely begin in 2018 and provide more limited downside risk than Track 2 of the MSSP. CMS will likely designate Track 1 Plus ACOs as Advanced APMs. CMS stated that it will announce additional information concerning this model in the future.

SMALL AND RURAL PRACTICES

In addition to the transition year, the Low-Volume Threshold, and flexible options for participation in MIPS, CMS has offered several other methods to reduce the burden on small and rural eligible clinicians transitioning to the QPP. CMS will permit small practices of less than 10 clinicians to join virtual groups and combine their MIPS reporting for a single performance year. In addition, CMS will make available $100 million in technical assistance for small and rural practices and practices in health professional shortage areas, with priority given to those practices in rural areas.

CONCLUSION

The Final Rule marks a significant departure from traditional Medicare reimbursement, but CMS has made an effort to ease the transition to value-based payments by allowing eligible clinicians to choose from several participation options and by providing a transition year in which the cost category will not affect a MIPS-participating eligible clinician's Medicare reimbursement. CMS expects the QPP to change and evolve over time in response to stakeholder input and seems to be willing to work collaboratively to ensure the success of the QPP. The iterative process that CMS outlined in implementing the QPP indicates that it may be willing to maintain its flexibility after the transition year, increasing the chances that eligible clinicians may be successful in this initiative.

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