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## Making Sense of the MACRA Final Rule Part 1 of 3: Essential Concepts

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On Oct. 14, the Centers for Medicare & Medicaid Services (CMS) published a final rule with comment period implementing the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The nearly 2,400 pages of regulatory text and associated commentary found in the unpublished version submitted to the Office of Management and Budget sets forth CMS’ implementing regulations to replace the Medicare sustainable growth rate (SGR) formula with a new system that links Medicare fee-for-service (FFS) payments for physicians and other practitioners to care delivery, quality and value-based variables.

**MACRA is viewed by many as a game changer for the delivery and payment of health care services. And since MACRA was a bipartisan piece of health care legislation, those expecting a repeal or major rewrite may be engaged in wishful thinking.**

MACRA’s implementation begins in earnest on Jan. 1, 2017. This is the first of a three-part series that examines various legal, operational and strategic considerations associated with the law and final rule.

This article examines certain essential concepts related to the “Quality Payment Program” (QPP) established by MACRA and implemented by CMS via the final rule, with attention to the QPP’s policy objectives, alternative participation vehicles, and certain operational concerns including what physicians and other “eligible clinicians” will be subject to the law and key participation-related choices.

Separate alerts in this series examine the specific details of MACRA’s participation alternatives:



- The Merit Based Payment Incentive System (MIPS); and
- Alternative Payment Models (APM)

Overall, this series examines MACRA and the final rule to provide practical observations and guidance to help position health care organizations for future success.

### MACRA Basics and Policy Objectives

MACRA is sufficiently detailed that it's easy to get lost in the weeds. As a practical matter, the QPP mandated by MACRA requires clinicians to participate in the evolving "value-based" payment and delivery system in a way that is intended to impact the delivery of FFS Medicare. The rule applies to Medicare Part B payments for professional services furnished by the vast majority of all physicians and other individual practitioners furnishing services under Medicare. These practitioners can participate in the QPP and influence the Part B payments they will receive by:

1. Choosing to participate in an Alternative Payment Model (APM) such as a Medicare Shared Savings Program (MSSP) accountable care organization (ACO) and certain other programs, and adhering to the quality, value and other requirements of the selected APM, or
2. Attesting to various self-reported measures focused on clinical quality, technology and new approaches to care delivery as required by the Merit Based Payment Incentive Program (MIPS).

From a policy perspective, MACRA and the QPP seek to:

- Require rapid migration from straight FFS to a largely "pay-for-value" payment system as consistent with CMS' stated goal of linking 90 percent of Medicare FFS payments tied to quality or value by the end of 2018;
- Encourage migration to "Advanced APM" models and reward those groups of participating providers who take the initiative (and bear the financial and other risk)

to try to succeed in such programs; and

- Establish MIPS as a means to link the fee-for-service payments made to the vast majority of physicians and other individual practitioners to measures directed at improving quality, innovation and value.

Overall, MACRA and the QPP establishes two alternative participation vehicles through which payment for physician and other practitioner services under Medicare Part B become subject to positive or negative payment adjustments.

APMs. The first QPP pathway involves Advanced Payment Models or "APMs" in which clinicians and groups may choose to participate in initiatives directed at changing how care is delivered, such as the MSSP, the Comprehensive Primary Care Plus (CPC+), and certain other Medicare payment initiatives.

Those clinicians and groups who participate in APMs are subject to the APM's quality, cost, data reporting, performance and potential payment incentives under the particular APM program. Participants in APMs also have the potential to be excepted from the MIPS payment adjustments. Those who participate in "Advanced APMs" during the first six QPP performance years will receive a guaranteed 5% positive lump-sum payment in the APM payment year. Such lump sum payments are in addition to any payments (or losses) under the APM itself. Clinicians participating in Advanced APMs also receive 0.75% annual fee schedule updates beginning in 2026.

MIPS. The second "fallback" QPP participation vehicle, the Merit Based Payment Incentive System or "MIPS" program, consolidates and streamlines components of three existing CMS programs that MACRA ends as of Dec. 31, 2018. Under MIPS, clinicians or groups will be measured and assessed





upward or downward payment adjustments based on their achievement in four performance categories:

- Quality (replacing the Physician Quality Reporting System (PQRS))
- Resource use (measuring cost of care and replacing the Value Based Payment Modifier VBM)
- Improvement activities (such as operating a patient centered medical home, promoting care coordination etc.), and
- Advancing care information (ACI) (replacing the Electronic Health Record Incentive Program (EHR) also called meaningful use (MU)).

Physicians, certain other advanced practice clinicians, and eventually other professionals, will be required to report information and be measured on these four MIPS performance categories beginning in 2017 as the QPP's first performance year. Under MIPS, performance in a defined performance year determines whether a clinician or group receives positive or negative payment adjustments during a payment year two years hence. The performance and payment years for MIPS and APMs during the first few years of the QPP can be summarized as follows:

Performance Year	Payment Year	MIPS Positive or Negative FFS Payment Adjustment (plus possible additional exceptional performance (EP) incentive)	APM Lump Sum Payment in Payment Year
2017	2019	+/- 4% (plus possible EP)	+5%
2018	2020	+/- 5% (plus possible EP)	+5%
2019	2021	+/- 7% (plus possible EP)	+5%
2020	2022	+/- 9% (plus possible EP)	+5%
2021	2023	+/- 9% (plus possible EP)	+5%
2022 and later years	2024 and later years	+/- 9% (plus possible EP)	+5%

MACRA provides an additional \$500 million for payment to "exceptional performers" under MIPS during the QPPs initial six years (through the 2024 payment year).

By law and with limited exceptions, the MIPS program will be implemented on a budget neutral basis – so there will be financial winners and losers. CMS projects that approximately \$199 million dollars will be equally distributed in a budget neutral manner for positive and negative MIPS adjustments. Beginning in 2026, clinicians who are subject to MIPS will receive a 0.25% annual fee schedule payment update (a lower update than the 0.75% received by clinicians participating in Advanced APMs).

### 2017 as "Pick Your Pace" Transition Year

As noted above, the QPP will assess clinician performance and use that assessment to impact Medicare payments two years hence, such that the 2017 performance year will determine whether Medicare Part B payments to eligible clinicians who are subject to MIPS will be subject to a plus or minus 4% adjustment in 2019 and so on.

Nonetheless, in the final rule, CMS defined 2017 as a transition year in response to widespread physician, hospital and other stakeholder concerns about the administrative burden of preparing to participate beginning on January 1, 2017. During the transition performance year, CMS permits eligible clinicians to "pick their pace" of QPP participation by choosing one of three MIPS pathways, or by participating in an Advanced APM and qualifying for an incentive payment.

During the 2017 transition year, the performance period for full reporting has been set at 90-days, reflecting a reduction from one year as originally proposed. The alternative QPP



participation strategies for 2017 and the potential payment implications in 2019 can be summarized as follows:

2017 Participation Strategy	2019 MACRA Payment Implications
<u>Highest Level Performance Options</u> <ul style="list-style-type: none"><li>Report all required MIPS measures for a full 90-day performance period and up to the full year.</li><li>Or</li><li>Participate in APM and qualify as an Advanced APM by meeting Medicare payment or patient thresholds in 2017</li></ul>	<ul style="list-style-type: none"><li>Avoid negative MIPS payment adjustment and maximize chance to qualify for a positive MIPS payment adjustment, with possibility to qualify for additional “exceptional performance” adjustment</li><li>Receive 5% lump sum bonus incentive payment in 2019.</li></ul>
<u>Moderate Performance Option</u> <ul style="list-style-type: none"><li>Report MIPS for a full 90-day period (but less than a full year) and report more than one quality measure, more than one improvement activity, <u>or</u> more than the 4 required measures in the ACI performance category</li></ul>	<ul style="list-style-type: none"><li>Avoid negative MIPS payment adjustment and eligible to receive a positive MIPS payment adjustment</li></ul>
<u>Passing Performance Option</u> <ul style="list-style-type: none"><li>Report one measure in each of the quality and improvement performance categories, <u>or</u> report the 4 required measures in ACI performance category</li></ul>	<ul style="list-style-type: none"><li>Avoid negative MIPS payment adjustment (but not eligible for potential positive adjustment)</li></ul>
<u>Failure to Participate Performance Option</u> <ul style="list-style-type: none"><li>Fail to report one measure or activity in the MIPS performance categories</li></ul>	<ul style="list-style-type: none"><li>Subject to -4% MIPS payment adjustment in 2019</li></ul>

## Practical and Operational Concerns -- Developing a MACRA Game Plan

The complex MACRA law and regulations include many highly technical details, so a framework and game plan can help health care organizations determine a strategy to succeed under the program.

To start, as of the date the MACRA final rule’s publication,

most physicians, other clinicians and their practices have already made a decision whether to participate in an APM beginning in 2017. For example, physician group practices (represented by tax-identification number or TIN) needed to choose to participate in an APM such as a MSSP ACO by mid-to late-summer 2016 – so the train has already left the station for many forms of APM participation in the 2017 performance year. Practices and their associated clinicians that have not already opted to be in an APM will most likely be subject to MIPS during the 2017 performance year.

And even those clinicians who are signed up to participate in an APM in 2017 (and who will therefore be subject to the APM’s specific reporting, performance and other requirements), are also “MIPS eligible clinicians” if that APM does not qualify as an Advanced APM and meet other requirements – meaning that despite their engagement with an APM, clinicians may still be subject to the MIPS program.

## MIPS Eligible Clinicians

Clinicians who bill under the Medicare Physician Fee Schedule (MPFS) and meet the definition of an “eligible clinician” must participate in an APM or MIPS, and those who are “MIPS eligible clinicians” are subject to potential MIPS payment adjustments. In the final rule, CMS finalized its proposed definition of MIPS eligible clinicians to include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups that include such clinicians. The definition will be expanded to include additional eligible clinicians through future rulemaking.

In the final rule, CMS also finalized its proposal to exclude from the definition of “eligible clinicians,” three defined classes of clinicians:





1. New Medicare-enrolled eligible clinicians (defined, generally, as those who first become a Medicare-enrolled eligible clinician during a defined performance year, e.g., 2017, and who have not previously submitted claims under Medicare either as an individual an entity, or as part of a physician group or under a different billing number or TIN). During the 2017 transition year, because CMS has provided that the transitional performance period will be a minimum of one continuous 90-day period of performance, CMS plans to conduct eligibility determinations on a quarterly basis to identify new Medicare-enrolled eligible clinicians who are excluded from the MIPS participation requirement. Persons who qualify as new Medicare-enrolled eligible clinicians will not be included in the applicable performance period for a year.
2. Non-patient facing (low volume) and RHC/FQHC eligible clinicians (defined generally as clinicians who do not have significant Medicare patient contact such that they do not meet a “low volume threshold”). In the final rule, CMS responded to concerns relative to MACRA’s likely disproportionate impact on small and independent practices, in part, by raising the final rule’s low volume threshold to \$30,000 or less in Medicare Part B allowed charges, or serving 100 or less Medicare patients in a year. Raising the low volume threshold will increase the number of clinicians who will be exempted from MIPS participation. Clinicians who qualify as non-patient facing eligible clinicians are not exempt from participating in MIPS or a performance category entirely; but they are subject to alternative measures or activities to fulfill the goals of a MIPS performance category or in some instances, performance categories will be re-weighted if sufficient applicable and available measures do not exist. Also, clinicians who are paid under rural health clinic and federally qualified health center methodologies are exempt from MIPS. These clinicians will have the option to voluntarily report data but will not be subject to any payment adjustments.
3. Qualifying APM Participants (QPs) or Partial Qualifying APM Participants (Partial QPs) (defined generally as

clinicians who participate in certain Advanced APMs during the applicable performance year). During the applicable performance year, since these clinicians are participating in an Advanced APM that fully or partially meets the applicable Advanced APM payment or patient count thresholds, they will not be required to report MIPS data and therefore will not be subject to MIPS adjustments. However, clinicians who qualify as Partial QPs will have the option to choose whether to report under MIPS for an applicable performance period, which will in turn determine whether or not they will be subject to MIPS payment adjustments based on their performance during that performance period. Additional information relative to QPs and Partial QPs is provided in a separate article dealing with APMs.

### Performance Years and Payment Years

As noted previously, the performance year for MIPS is the calendar year two years prior to the year in which the MIPS adjustment is applied – meaning performance during the 2017 performance year defines the MIPS adjustment in the 2019 payment year, performance during the 2018 performance year defines the MIPS adjustment for payment year 2020, and so on. APMs are subject to the same two-year time lag between the time of performance, and the time in which the APM lump-sum bonus payment is made.

Under the final rule, no later than 30 days prior to Jan. 1 of the applicable payment year, CMS will determine the MIPS adjustment (including any exceptional performance adjustment) applicable to each MIPS eligible clinician. That MIPS adjustment will apply to increase or decrease the payment made to the applicable MIPS eligible clinician for Medicare Part B items and services furnished during the





payment year. This means, for example, that:

- Clinician performance during the 2017 performance year will determine the MIPS adjustment for the 2019 payment year
- The magnitude of that 2019 payment adjustment will be known no later than December 1, 2018, and
- The negative or positive (including exceptional performance) MIPS adjustment will apply to the clinician's Medicare claims in 2019.

In the final rule CMS established 2017 as a transition year. In doing so, the agency created flexibility regarding the magnitude or level of participation (i.e., amount and periods of data reporting) in the MIPS performance categories. The measures and activities under individual MIPS performance categories will be updated annually.

### Individual and Group Participation and Reporting Options

The final rule generally permits MIPS eligible clinicians to report necessary data and be measured on an individual clinician or group (i.e., practice TIN) basis. Clinicians participating in an APM will be subject to the particular reporting and measurement requirements of the APM—meaning, for example, that those participating in the MSSP are required to report quality performance through the ACO and report other metrics at the practice TIN (rather than individual) level.

Unless a MIPS eligible clinician or practice is participating in an APM, an initial decision will need to be made in 2017 regarding whether to report as individual clinicians, or as a group. For such purposes, a “group” is defined as a single TIN associated with two or more eligible clinicians who have their Medicare billing rights reassigned to the TIN. The group must meet this definition at all times during the performance period for the MIPS payment year in order for their performance to be assessed as a group.

Where performance is assessed as a group, the performance data of the group's MIPS eligible clinicians will be aggregated, assessed, and scored across the TIN, and that assessment will include services furnished by clinicians who do not qualify as eligible clinicians. Where the group reporting option is selected, performance will be assessed as a group across all four MIPS performance categories.

### Additional Reporting Rules

Individual performance measures under MIPS will be updated annually. In the final rule CMS also established that where individual eligible clinicians and groups have less than 12 months of performance data to report (e.g., due to switching practices during the performance period, medical leave etc.), the individual or group will be required to report all performance data applicable to the performance period. 2017 is a transitional performance period, so reporting level and time periods can vary for 2017. The performance period for the MIPS quality and cost performance categories will be the entire calendar year in 2018 and beyond.

### Projected QPP Impact – Near and Long Term

In the final rule, CMS estimates that between 592,000 and 642,000 eligible clinicians will qualify as MIPS eligible clinicians and therefore, they will be required to submit “some” data under MIPS in 2017. Only those MIPS eligible clinicians who fail to participate (i.e., fail to submit “some” data) during 2017 will be subject to the full negative 4% payment adjustment in 2019.

Applying average Medicare billings to total revenue, CMS estimates that even those MIPS eligible clinicians adversely affected by MIPS will “rarely” face losses in excess of 3% of their total revenue.







CMS received numerous comments and made changes in the final rule designed to mitigate the projected negative impact on solo, small, or rural practices. CMS will provide \$100 million in technical assistance to participating clinicians in small practices, rural areas and health professional shortage areas.

CMS takes the position that the negative impact on smaller practices of 1 to 9 clinicians under the final rule is significantly less than what was estimated in the proposed rule. This is for various reasons, including the final rule's expansion of what will now qualify "low volume" practices that are exempt from MIPS, the final rule's application to New Medicare-enrolled eligible clinicians, and the establishment of flexible options for submitting MIPS data during the 2017 transitional performance year.

CMS performed an updated Regulatory Impact Analysis, with details only through 2019. At a high level, CMS estimates that repealing the SGR payment reductions results in a net budgetary cost of \$102.8 billion for the combined ten year period 2016 - 2025. The largest component of the MACRA costs is its replacement of the SGR reductions with payment rates frozen at 2015 levels, then increasing at an overall rate of .05% per year during 2016 through 2019.

## Observations and Additional Information

In the final rule CMS sought to balance several potentially conflicting goals and objectives:

- The agencies' self-defined goal to link 90 percent of Medicare FFS payments to quality or value by the end of 2018
- A legislative mandate to implement the bipartisan MACRA legislation beginning on January 1, 2017,
- Over 4,000 comments from stakeholders in response to the highly complex proposed rule.

Overall, given MACRA's complexity, the final rule and the associated transition plan for 2017 represents a pragmatic, but

imperfect, approach to implementation. On this final point, CMS acknowledges that the final rule and the specific details of the MIPS and APM participation vehicles for the QPP will continue to change and evolve in the years ahead, so it's very much a work in progress.

Consult Polsinelli's separate articles dealing with the final rule's requirements and practical implications associated with: APMs (available Nov. 2, 2016) [here](#), and MIPS (available Nov. 3, 2016) [here](#).

The final rule is subject to a 60 day comment period following its anticipated publication in the Federal Register on Nov. 4, 2016, so comments are likely to be due on Jan. 2, 2017.

## For Additional Questions

These issues are complex and evolving. For additional questions or counsel on how this guidance may impact your business, please consult the authors or another member of Polsinelli's Health Care or Public Policy practices. Attorneys and other professionals in our Health Care and Public Policy practices stand ready to offer counsel on MACRA as a bipartisan piece of health care legislation.

## Sign up to participate

November 10, 2016 Polsinelli Reimbursement Institute Webinar: MACRA Final Rule: Key Implications and Strategies for Success, presented by Bruce A. Johnson and Sidney Welch. To register, click [here](#).





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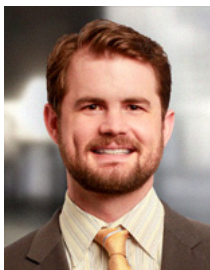
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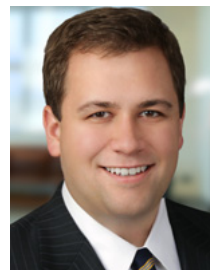
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\*2016 BTI Client Service A-Team Report

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