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CMS Releases MACRA Final Rule, Easing 2017 Reporting Requirements

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On October 14, 2016, the Centers for Medicare and Medicaid Services (CMS) released the final rule for the ***Medicare Access and CHIP Reauthorization Act of 2015 (MACRA***). The final rule marks the most significant reform to our health care system since the enactment of the Affordable Care Act in 2010, providing Medicare incentives to reward quality and value—not volume—through the use of alternative payment models such as accountable care organizations. The final rule includes changes that significantly soften certain requirements from the proposed rule, with CMS emphasizing that physicians will be allowed to "pick their pace" for satisfying MACRA requirements that begin on January 1, 2017.

A MACRA Refresher

CMS issued a proposed rule in late April of this year, much of which is unchanged in the final rule. For our previous discussion of MACRA, see our prior blog posts on: an overview of the MACRA and MIPS, Advancing Care Information, APMs, and flexible reporting requirements.

Starting in 2019, CMS will replace a number of existing reporting programs with a two track system, known as the Quality Payment Program, under which eligible clinicians will receive incentive reimbursement payments through either:

1. The Merit-Based Incentive Payment Systems (MIPS); or

2. Alternative payment models (APMs).

MIPS consolidates three existing Medicare programs: (1) the Physician Quality Reporting System, (2) the Physician Value-based Payment Modifier, and the (3) Medicare Electronic Health Record (EHR) Incentive Program. Under MIPS, eligible clinicians can receive incentive payment (or penalty) based on four categories of measures: quality, cost, improvement activities, and the use of EHRs. (These categories are discussed in greater detail below.) CMS will take the results and create a composite score that it will then use to increase or decrease the clinician's reimbursement under the Medicare Physician Fee Schedule (PFS). These adjustments will begin on January 1, 2019, and will be based on data collected in 2017. Clinicians scoring below a certain threshold will incur a negative

adjustment in their payments starting with a maximum penalty of 4% in 2019 and increasing to a maximum penalty of 9% in 2022 and beyond. Those scoring above the threshold can receive up to a 4% increase in 2019, with a maximum increase of 9% in 2022. High achievers will be eligible for an additional upward adjustment.

The second track is for clinicians participating in an "Advanced APM," including certain accountable care organizations (ACOs) and patient-centered medical homes. Advanced APMs essentially operate as more generous incentive programs that are exempt from the MIPS requirements. Those on the Advanced APM track can earn bonuses of up to 5% of their PFS payments in 2019. However, as discussed in further detail below, only ACOs accepting some amount of downside financial risk can qualify for the MIPS exemption.

The Final Rule

The Merit-Based Incentive Payment System (MIPS)

In response to numerous comments expressing deep concern over the timetable for reporting under MIPS, CMS is making the 2017 performance year a "transition year" with reduced reporting requirements, focusing on a goal of widespread participation and clinician education. We focus our discussion on this first transition year because of CMS's emphasis on providing flexibility for the beginning of the program. Only physicians who fail to report a minimum amount of data (discussed below) will receive the 4% negative adjustment in 2019. Those looking to avoid the negative adjustment under MIPS have three options:

1. *Full Reporting*. Report all of the required measures for a minimum of a continuous 90-day period. Clinicians using this option will be eligible to receive a moderate positive payment adjustment depending on their score.

2. *Partial Reporting*. Report on one "quality measure," more than one "improvement activity," or more than the required measures in the "advancing care information performance category," for a minimum of a continuous 90-day period. Clinicians using this option will receive either no adjustment or a small positive payment adjustment depending on their score.

3. *Minimum Submission*. Report on one quality measure, one activity in the improvement activities category, or report the required measures of the advancing care information category. This option does not require continuous reporting for a 90-day period. Clinicians using this option will not be eligible to receive a performance bonus, but will not be subject to a penalty.

Under the final rule, performance data can be collected starting on January 1, 2017. If clinicians need more time, they can delay collecting the data until no later than October 2, 2017, which is the first business day of the 4th quarter of 2017. However, CMS has stated that clinicians seeking to maximize their chances of qualifying for a positive adjustment should report as much data for 2017 as possible. The final rule has set a deadline of March 31, 2018, to report data to CMS regardless of the amount of data being reported. Clinicians can submit data either individually or through a group. The final rule also allows smaller practices to form "virtual groups" of up to ten clinicians for the purposes of reporting. Unfortunately, the virtual group option will not be available in 2017.

The calculation of the amount of the payment adjustment is based on a composite performance score in the following performance categories (scoring weights for 2017 are noted parenthetically):

1. *Clinical quality (60%)*. Performance is calculated based on the submission of quality measures chosen by the clinician. (The measures available to clinicians will be updated annually through a call for quality measures process.) Clinicians have the option of submitting general quality measures or specialty-specific quality measures.

2. *Advanced care information (25%)*. Performance is calculated based on the submission of five EHR use-related measures (six fewer required measures than in the proposed rule). These measures include: security risk analysis; e-prescribing; providing patient access; sending summaries of care; and requesting/accepting summaries of care. Importantly, the final rule eliminates the all-or-nothing approach to reporting under the proposed rule. CMS also allows optional measures to be submitted for a higher score.

3. *Clinical Improvement Activities (15%)*. Performance is calculated based on the clinician's attestation to having completed four clinical practice improvement activities. (This is a reduction from the six activities under the proposed rule.) Bonus scores are available for clinical improvement activities that use certified electronic health record technology (CEHRT) and for reporting to public health and clinical data registries. This is a new category and does not replace an existing program.

4. *Cost (0%)*. Performance under this category (referred to in the proposed rule as "resource utilization") will be calculated based on cost measures specified by CMS. Clinicians do not have to report data for this category—it is calculated independently by CMS. To address public comments, this category will not be factored into the performance scores for the first payment year 2019.

CMS also finalized the criteria that will be used to exempt low-volume Medicare providers from MIPS. Under the final rule, MIPS will not apply to practices with less than $30,000 in Medicare charges or fewer than 100 unique Medicare patients per year. The threshold was originally $10,000 in the proposed rule.

Advanced Alternative Payment Models (Advanced APMs)

Clinicians are exempt from MIPS and eligible for up to a five percent bonus payment if they receive a sufficient portion of their payments or see a sufficient portion of their patients through an Advanced APM. These clinicians are referred to as Qualified APM Participants or "QPs."

APMs seeking to qualify as an Advanced APM must meet what CMS describes as "ambitious but achievable goals," including:

1. The use of certified EHR technology;

2. Payment for covered professional services based on quality measures comparable to those in MIPS' quality performance category; and

3. Either (a) the bearing of downside financial risk in excess of a nominal amount or (b) being a nationally recognized accredited patient-centered medical home, expanded under section

1115A(c) of the Social Security Act.

In an attempt to increase the number of Advanced APMs and make them more palatable to providers, the final rule reduces the nominal amount of financial risk for 2017 and 2018 to eight percent of all Medicare reimbursement or three percent of the expected expenditures for which the clinician is responsible under the APM.

CMS anticipates that the following will be Advanced APMs for the 2017 performance year:

1. The Comprehensive ESRD Care – Two-sided risk;
2. Comprehensive Primary Care Plus (CPC+);
3. Next Generation ACOs; and
4. Medicare Shared Savings Program – Tracks 2 and 3.

In a further attempt to increase the number of Advanced APMs, CMS announced in the final rule that it will explore the development of a new ACO model to begin in 2018. This new model, referred to as ACO Track 1+, will allow those currently participating in Medicare Shared Savings Program Track 1 ACOs to take on enough downside risk to qualify as an Advanced APM. CMS also predicts the creation of additional models.

CMS acknowledges that some clinicians will participate in APMs that are not considered Advanced APMs. Clinicians in these APMs are subject to MIPS' reporting requirements and payment adjustments. However, CMS is providing some relief to physicians in these APMs—which CMS confusingly refers to as MIPS APMs—by scoring their performance using the APM scoring standard instead of the applicable MIPS standards.

Commentary

Although initial indicators suggest that health care industry provider groups are pleased with the flexibility CMS is trying to achieve in the transition year, the Quality Payment Program reform under MACRA will require a significant amount of provider resources to implement. CMS believes, based on PQRS in 2015 reporting, that a substantial number of solo and small practices will be able to successfully input data in the new system. Notwithstanding this optimism, CMS is dedicating $20 million per year for the next five years to provide small practices with technical assistance on MIPS and advice on their potential transition to Advanced APMs. Whether enough practices will actually transition to Advanced APMS—which is MACRA's overriding goal after all—is one of the most difficult questions facing CMS. It is likely these MACRA changes will also further drive the consolidation of small group practices to be able to better position themselves to receive the incentive payments under the Quality Payment Program.

One area where clinicians will soon find relief is the transition away from the widely criticized Meaningful Use Program which ends with the implementation of the MACRA incentive payments in 2019. Instead, physicians will be reported more simplified advanced care information data under MIPS.

It is clear CMS went out of its way to make it relatively easy for practitioners to avoid a negative payment adjustment, and for many practitioners to submit a simplified set of data and thereby earn some limited positive payment adjustment. However, this accommodation is only temporary. Whether a one-year transition period will be sufficient remains to be seen. What is certain is that a successful transition to MIPS with wide participation is essential for the program given the large number of clinicians that will be participating on the MIPS track.

CMS understands that widespread clinician participation in Advanced APMs is unlikely, estimating a participation rate in the transition year of only 70,000 and 120,000 clinicians. CMS is clearly interested in encouraging clinician participation in APMs, as evidenced by the planned introduction of the ACO Track 1+ model.

This MACRA final rule is the start of a long journey in Medicare fee-for-service payment reform, brought about by rare bipartisan Congressional compromise legislation based on the common understanding that for Medicare to achieve long-term sustainability, volume-based incentives need to be replaced with rewards for quality and patient-centered care. To come in future years are more rigorous targets, including scoring for cost performance, with CMS actually providing clinical feedback to clinicians on their reported performance.

CMS will be accepting feedback on the final rule for 60 days after the rule is published.

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