

MACRA: Redefining How CMS Pays Doctors

Second Edition
White Paper



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Abstract: The Medicare Access and CHIP Reauthorization Act (MACRA), passed in April 2015, is a landmark piece of legislation that represents a dramatic change in the way CMS will pay healthcare professionals. While complex and not entirely defined, all providers should learn as much as possible about MACRA to avoid costly under- or overreactions to the new requirements. The reader will receive definitions of many unfamiliar terms and acronyms that are result of the legislation. This paper addresses the significant changes in quality reporting systems, billing systems, and most importantly care delivery systems that will be required to operate successfully under MACRA rules and regulations. Preparation should start immediately in provider organizations affected by MACRA.

Key Words: MACRA, SGR, CMS, MIPS, APM, PQRS, VPM, CPIA, ACI, MU, additional performance threshold, Cost Measurements and the Value Modifier Program, PCMH, CPOE, CDS, Medicare Shared Savings Plans, Next Generation ACO Model, Comprehensive End-stage Renal Disease (ESRD) Care, Comprehensive Primary Care Plus, Oncology Care Model, CEHRT, BPCI, QPs, Advanced APMs.

INTRODUCTION

The Medicare Access and CHIP Reauthorization Act (MACRA), which passed in April 2015, replaced the sustainable growth rate (SGR) as a way for the Centers for Medicare and Medicaid Services (CMS) to adjust payments to physicians both to drive quality and control costs within the Medicare system. Further, MACRA consolidates multiple quality reporting programs into the Merit-based Incentive Payment System (MIPS) and also provides incentives for participation in Alternative Payment Models (APMs) and Advanced Alternative Payment Models (AAPMs).

On April 27, 2016, CMS issued a Notice of Proposed Rulemaking regarding various provisions of MACRA. On October 18, 2016, CMS released its final rule regarding MACRA. The intent of this paper is to provide the reader with an up-to-date summarization of this complex legislation. Undoubtedly, this information will need to be refined as CMS issues further directives on MACRA between now and the Act's implementation in early 2017.

REPLACING THE SGR

The SGR was originally designed to control the rate of growth in physician payments by Medicare. Ultimately, this mechanism proved to be extremely unpopular and unworkable, requiring annual interventions by Congress to avoid implementing draconian cuts in payments to certain medical specialties. MACRA specifically increases physician payments by 0.5% each year from 2016 to 2019. There are no planned increases in payments from 2020 to 2025; from 2026 on, the CMS fee schedule will increase annually 0.25% for APMs and 0.75% for AAPMs.

OVERARCHING GOALS OF MACRA

While also repealing the SGR, MACRA created the Quality Payment Program (“QPP”). QPP encompasses both the MPS and the APM payment programs. CMS has two primary goals for the quality payment program included in MACRA, i.e., MIPS. These goals are:

1. 30% of Medicare physician payments will be tied to value through APMs by the end of 2016, and 50% of those payments will be tied to value by the end of 2018; and,
2. 85% of total Medicare payments will be tied to quality or value by the end of 2016, and 90% by the end of 2018.¹

MIPS

Payment adjustments under the MIPS program will begin in January of 2019; however, provider performance on various measures will be measured beginning in January of 2017. In the first two years, eligible participants will include physicians (MDs, DOs) Dentists (DMDs, DDSs), physician assistants, nurse-practitioners, clinical nurse specialists, and certified registered nurse anesthetists. In year three and beyond, this list will expand to include physical or occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, and dietitians or nutritional professionals. Participants in MIPS can be single clinicians or practice entities, and the choice of participating individually or within groups is left up to the providers.²

Providers who are participating in their first year with Medicare Part B and those who have Medicare billing charges less than or equal to \$30,000 or who provide care for 100 or fewer Medicare patients in one year will not be eligible for participation in MIPS. Others who will be ineligible to participate in MIPS are those providers participating in an Advanced Alternative Payment Models and hospitals or other facilities.³

¹ *Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value,* Department of Health and Human Services (January 26, 2015) (last accessed May 23, 2016). <<http://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html>>

² *“MACRA NPRM Overview,”* Centers for Medicare and Medicaid Services (last accessed May 17, 2016) <<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-Events.html>>.

³ *“MACRA NPRM Overview.”*

MIPS will measure participant performance through a composite score that takes into account four factors:

1. Quality;
2. Resource use;
3. Clinical practice improvement activities (CPIA); and,
4. Advancing care information (ACI).

MIPS then consolidates these four previously voluntary performance measuring programs into one mandatory reporting system.

Resource use measurements will compare cost efficiency for similar care episodes across practices and will be risk-adjusted. CPIAs will track activities such as care coordination, shared decision-making, safety checklists, and expanding practice access and ACI metrics will mirror those measures now in place under the meaningful use program.⁴

Each of the above categories of performance within MIPS also will be weighted, with Year One performance weights distributed as follows:

Cost - 10%
Quality - 50%⁵
ACI - 25%, and,
CPIA - 15%

These weightings are expected to change as the program evolves and takes into account alterations in the delivery system, such as an increase in providers who adopt electronic health records, and comply with meaningful use criteria. Expectations are that the MIPS quality component will decrease to 30% after year one while the cost component increases to 30%.

Currently, there are six sub-categories within the quality component of MIPS. These include protection of patient health information, electronic prescribing, patient electronic access, coordination of care through patient engagement, health information exchange, and public health and clinical data reporting. A maximum of 10 possible points for each quality category will be assigned depending upon how the clinician compares to benchmarks established by CMS. CMS also will score clinicians on up to three population-based measures calculated from the provider's Medicare administrative claims. Thus, there will be a maximum of 90 points possible

⁴ "MACRA NPRM Overview."

⁵ Because the cost factor will not be taken into account for the first year, quality will account for 60% of a provider's composite score for the first year only. See note 8, *infra*.

if the clinician chooses to report on the six quality sub-categories and the three population health measures.⁶

As opposed to the quality category, there is no possibility for bonus points in the cost category. After receiving many comments from providers after issuing the proposed rule, CMS modified the rule to state that the cost category will not be taken into consideration when determining the first year's payment adjustment; however, beginning in 2018, the cost category will be considered when determining a payment adjustment.⁷ The key changes expected between the MIPS Cost Measurements and the Value Modifier Program is that MIPS will add 40+ episode specific measures to address specialty concerns.⁸

In the MIPS CPIA category, the final rule gives full or partial credits to providers or group who engage in at least one CPIA activity (out of 90+ proposed activities) with one additional credit given for more activities. Physicians working in a patient-centered medical home (PCMH) will be given full credit, and those participating in other APMs will start with half-credit.⁹ Other CPIAs are defined as "activities that relevant eligible clinician organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary of HHS determines when effectively executed are likely to result in improved outcomes."¹⁰ CMS will assign credits for each reported activity with medium-weighted and high-weighted sub-categories. The clinician or group must report three high sub-categories and six medium sub-categories to achieve the highest possible score, although the proposed rule says there is no minimum number of sub-categories on which the entity or clinician must report.¹¹ Sub-categories now include expanded practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, achievement of health equity, emergency response and preparedness, and integrated behavioral and mental health. A full list of the sub-categories is available in Table H of the Notice of Proposed Rulemaking.¹²

The MIPS-ACI performance category will allow for a total of 100 or more points to be credited to each provider or group. Factors considered in the score include protection of patient health information, electronic prescribing of medications, patient electronic access to medical records, coordination of care through patient engagement, health information exchange, and public health and clinical data registry reporting. This scoring differs significantly from the previous

⁶ *Id.*

⁷ *What's the Merit-based Incentive Payment System (MIPS)?*, Centers for Medicare and Medicaid Services, (last accessed October 30, 2016), <https://qpp.cms.gov/learn/qpp>.

⁸ *Id.*

⁹ *Id.*

¹⁰ 81 Federal Register 28181 (May 9, 2016).

¹¹ "MACRA NPRM Overview."

¹² This Notice of Proposed Rulemaking can be found at <https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf>

meaningful use incentive program in that MIPS will remove redundant measures to ease reporting requirements, eliminate clinical provider order entry (CPOE) and clinical decision support (CDS) objectives, and reduce the number of required public health registries to which clinicians must report.¹³

Once implemented in 2019, the MIPS composite performance score (CPS) that factors in the scores from all four (subject to the cost accounting category not being considered in 2017) categories described above will be used to adjust physician payments up or down by 4% in the first year, increasing to an up or down adjustment in 2022 of 9%. A MIPS-eligible clinician's payment adjustment percentage is based on the relationship between their CPS and the MIPS performance threshold. A CPS below the threshold will yield a negative payment adjustment, and a CPS above the threshold will yield a neutral or positive adjustment.¹⁴ For instance, a CPS less than or equal to 25% of the threshold will yield the maximum negative adjustment of 4% in the first year. An additional bonus (not to exceed 10%) will be applied to payments to eligible clinicians with exceptional performance where the CPS is equal to or greater than an *additional performance threshold* defined as the 25th percentile of possible values above the performance threshold.¹⁵

Once CMS calculates the initial payment adjustments for the MIPS-eligible providers, CMS can positively adjust the payments up to a factor of 3 in order to achieve budget neutrality of the MIPS payments. For example, a provider who would originally receive a payment adjustment of 4% could be eligible to receive a maximum positive adjustment of 12% if CMS was required to triple the payment adjustment in order to achieve budget neutrality. CMS intends to set the payment threshold so that 50% of eligible clinicians will receive a favorable adjustment and 50% will receive a negative adjustment. This alteration will result in budget neutrality for CMS as it relates to MIPS payments. As mentioned, exceptional performers will receive additional positive adjustment payments from a bonus pool of \$500 M each year from 2019 through 2024, and these payments are not subject to the budget neutrality provision of MACRA.¹⁶

Since publishing the proposed rule, CMS has lightened the burden for providers in regards to their participation and reporting of data from 2017. First, the provider can choose to not participate in the MIPS program. In that event, the provider will receive a -4% payment adjustment in their Medicare payments. Second, the provider can submit a minimum amount of 2017 data (data as it pertains to one measure or activity). If the provider chooses to submit the bare minimum, the provider will neither receive a payment increase nor decrease. Third, the provider can submit 90 days of 2017, wherein that provider will earn a small positive or neutral

¹³ "MACRA NPRM Overview."

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

payment adjustment. Finally, if the provider fully participates in the MIPS program and submits a full year of data, the provider will earn a moderate positive payment adjustment.¹⁷

Providers must submit their 2017 data by March 31, 2018. CMS has stated that they will provide feedback regarding the provider's 2017 data in 2018. Finally, as stated earlier, the payment adjustments will be received in 2019.¹⁸

ALTERNATIVE PAYMENT MODELS (APM)

Eligible professionals who are deemed to be Qualified Participants will be excluded from MIPS and instead receive a lump sum incentive payment of 5% for that year. Those that do not qualify as Qualified Participants but who still participate in an APM are deemed MIPS-APMs.

APMs include the CMS Innovation Center Medical Home Model, the Medicare Shared Savings Programs and other demonstrations required by federal law, such as the Bundled Payment Care Initiative (BPCI).

Advanced APMs must meet the following criteria:

- Use certified EHR technology--APMs require at least 50% of eligible clinicians in each APM to use CEHRT to document and communicate clinical care; this requirement will increase to 75% after the first year;
- Base payments on quality measures comparable to those in the MIPS quality performance category--there are no minimum number of measures except that an advanced APM must have at least one outcome measure unless there are no appropriate outcome measures available; and,
- Require APM participants to bear more than nominal financial risk--the advanced APM must bear risk for monetary losses and that risk must meet a certain threshold, such as 3% of total expenditures and 30% marginal risk. Furthermore, the financial risk criteria for APMs require that if actual expenditures exceed expedited expenditures, there must be a direct payment from the APM to CMS or a reduction in payment rates to the APM entity or eligible clinicians or withholding of payment to the APM or eligible clinicians.¹⁹

CMS expects the following models to qualify as Advanced APMs in 2017:

- Medicare Shared Savings Plans (tracks 2 and 3)

¹⁷ *Quality Payment Program*, Centers for Medicare and Medicaid Services, (last accessed October 30, 2016), <https://qpp.cms.gov/>

¹⁸ *Id.*

¹⁹ "MACRA NPRM Overview," *supra* note 12.

- The Next Generation ACO Model
- Comprehensive End-stage Renal Disease (ESRD) Care (large dialysis organization arrangements)
- Comprehensive Primary Care Plus and the Oncology Care Model (two-sided risk track available in 2018)²⁰

Qualified participants in advanced APMs will be excluded from participating in MIPS. They will qualify, however, for a 5% lump sum payment based on the estimated aggregate payment amounts for Part B covered professional services for the preceding year, provided the provider receives 25% of their Medicare Part B payment through the APM, or that the provider sees 20% of their Medicare patients through the advanced APM.²¹ These bonuses will apply from 2019 through 2024, with a higher fee schedule to be introduced after 2024.

MIPS-APMs will receive APM-specific benefits but still need to submit data to MIPS, where they will receive a positive payment adjustment. The final rule eased the burn on reporting for MIPS-APMs, as they will be scored using the APM scoring standard instead of the MIPS scoring system.²² Qualification or eligibility to participate in an APM will be determined at the APM entity level, and all clinicians deemed eligible will be assessed together by CMS.²³

In order to be deemed a Qualified Participant who may participate in an advanced APM, CMS will then calculate a percentage *threshold score* for each entity using either a payment amount (based on Medicare Part B professional service payments) or patient count (the number of beneficiaries attributed to the APM entity). CMS will use the most favorable method for each entity.²⁴

Under the payment amount method, the threshold score will be equal to the Part B payments for professional services received by the entity for attributed beneficiaries divided by the payments for Part B professional services to all attribution-eligible beneficiaries. Under the patient count method, the threshold score will be determined by dividing the number of attributed beneficiaries given Part B professional services by the number of attribution-eligible beneficiaries given Part B professional services.

During 2019, the first year of the program, the qualified participant payment amount threshold score for full payment will be 25%; for partial payment, it will be 20%. The threshold scores using the patient count method in 2019 will be 20% for full payment and 10% for partial

²⁰ “MACRA NPRM Overview.”

²¹ *What are Alternative Payment Models (APMs)?*, Centers for Medicare and Medicaid Services, (last accessed October 30, 2016), <https://qpp.cms.gov/learn/apms>.

²² *Id.*

²³ *Id.*

²⁴ *Id.*

payment. Both the full payment and partial payment threshold scores will increase year by year until 2024, where the full-payment threshold will be 75% and the partial-payment threshold will be 50%.²⁵

The timeline for payments to qualified participants (QP) in APMs begins in 2017 when the qualified participants' eligibility will be determined by their participation in an APM. In 2018, the payments to each QP will be totaled, and in 2019, each QP who participates in an APM that meets or exceeds the threshold score will receive up to a 5% lump sum payment. This timeline will repeat each year after that. Those QPs whose APMs do not meet the full payment thresholds will not receive the 5% APM incentive but will be eligible to receive a favorable MIPS adjustment.

While individual providers can report data by themselves or as part of a group, the final rule further eased the burden MACRA requires of small practices by allowing for "virtual groups" of up to 10 physicians to combine and report their data; however, this option will not be available in 2017.²⁶

Note that MACRA does not alter the structure or payment of the various APMs; it merely provides an additional incentive for participating in these programs or models.²⁷ Also, a comparison of APMs and Advanced APMs shows APMs are automatically subject to favorable MIPS adjustments and are eligible for APM-specific rewards. Advanced APMs, however, are excluded from MIPS adjustments, may receive APM-specific rewards, and obtain a 5% lump sum bonus.²⁸

MEDICAL HOMES

Under MACRA, medical homes have a unique financial risk criterion for becoming Advanced APMs and enables participants not excluded from MIPS to receive the maximum score in the MIPS CPIA category. This rule is designed to emphasize the importance of primary care, to foster the pairing of each patient/beneficiary with a primary care clinician, and to foster chronic and preventive care, continuity of care, risk-stratified care management, coordination of care across the medical neighborhood, patient and caregiver engagement, shared decision-making and payment arrangements that substitute for fee-for-service payments.²⁹ In fact, CMS has stated that as of November 1, 2016, the only model that qualifies as a medical home is the

²⁵ *Id.*

²⁶ Billy Winne, *MACRA Final Rule: SMS Strikes a Balance; Will Docs Hang On?*, Health Affairs Blog, (October 17, 2016) (last accessed October 30, 2016), <https://healthaffairs.org/blog/2016/10/17/macra-final-rule-cms-strikes-a-balance-will-docs-hang-on/>.

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.*

Comprehensive Primary Care Plus program. In order to qualify as a medical home, the model must meet the following requirements:

1. The model must focus on primary care;
2. The model must offer primary care services with patients that have a primary care physician; and
3. The model must have four of the following elements:
 - a. The model must coordinate chronic and preventative care;
 - b. The model must allow for patient access and continuity of care;
 - c. The model must have risk-stratified care management;
 - d. There must be a coordination of care across the medical community;
 - e. There must be engagement between the provider and the patient;
 - f. The model must allow for shared decision-making
 - g. The model must allow for payment arrangements (shared savings, population health payment arrangements).³⁰

Risk requirements for Medical Homes are similar to other APMs and include the following if the medical home does not meet a specified performance standard: direct payment from the MH, reduction in payment rates to the MH, withholding of payment to the MH, or reduction of otherwise guaranteed payments to the MH. Finally, the nominal amount that must be at risk for Medical Homes is defined in the proposed rule as 2.5% of Medicare Parts A and B revenue in 2017, 3% in 2018, 4% in 2019, and 5% in 2020.

CONCLUSION

The Medicare Access and CHIP Reauthorization Act is a landmark piece of legislation and represents a dramatic change in the way CMS will pay healthcare professionals. While complex and not completely defined, all providers should avail themselves of as much information about MACRA as possible. Preparatory efforts should start immediately in provider organizations affected by MACRA. Significant changes in quality reporting systems, billing systems, and most importantly care delivery systems will be required to operate successfully under MACRA rules and regulations. Implementing these changes will require a detailed understanding of this legislation and careful planning to avoid costly under- or overreactions to the new requirements.

³⁰ *Executive Summary of the MACRA Final Rule*, American Academy of Family Physicians 5, (last accessed October 30, 2016), accessed at www.aafp.org/dam/AAFP/documents/advocacy/payment/medicare/ES-MACRAFinal-102416.pdf.