SQUIRE PATTON BOGGS

CMS Publishes Final Rule Implementing MACRA

On Friday, October 14, 2016, the Centers for Medicare and Medicaid Services (CMS) issued its Final Rule with Comment, implementing the Quality Payment Program (QPP) delineated in the Medicare Access and Chip Reauthorization Act of 2015 (MACRA). The QPP is designed to reward delivery of high-quality patient care through two programs: Advanced Alternative Payment Methods (Advanced APM) and the Merit-based Incentive Payment System (MIPS). The Rule establishes incentives to participate in Advanced APMs, as well as requirements for Qualifying Advanced APM Participants (QP) to receive additional incentive payments for reaching efficiency and care thresholds. Additionally, the Rule establishes the MIPS program that will make forward-looking payment adjustments for certain clinicians based on performance in four areas: cost, quality, advancing care information and improvement activities.

This Rule represents a major change in the way Medicare service providers report to CMS and receive their payments. However, CMS recognizes that change could not happen overnight, and that an adjustment period may be necessary. To this end, CMS is also implementing a two-year transition period allowing clinicians to gradually familiarize themselves with the new reporting structures in order to help as many clinicians as possible realize the full potential of the new programs.

The Quality Payment Program

The QPP is the program MACRA created to facilitate MIPS and Advanced APMs. CMS's focus in implementing the QPP is to drive significant change in how care is delivered to make it more responsive to patients and their families, and to use the QPP to support physicians in improving the health of their patients. The QPP's main goals are to:

- Improve care by focusing on outcomes for patients, decrease provider burden, while preserving independent clinical practice
- Promote the Advanced APMs that bring together healthcare stakeholders in determining incentives
- Advance existing efforts of delivery system reform

The QPP's two avenues for achieving its goals, Advanced APMs and MIPS, were created in order to allow clinicians and physicians to deliver coordinated and high-quality care in a streamlined payment system and to improve the quality of patient care.

Advanced Alternative Payment Models (Advanced APM)

An Advanced APM is a payment approach designed to contribute to better care and smarter spending by CMS through providing added incentives to high-quality and cost-efficient care. The approaches used in Advanced APMs are developed in partnership with clinicians and physicians, and designed to evolve to ensure beneficiaries continuously receive the highest quality of care.

There are three criteria that a method must meet to be considered an Advanced APM:

- The APM must require that participants use certified electronic health record technology (CEHRT)
- The APM or payment arrangement must provide for covered professional services based on quality measures comparable to those in the quality performance category under MIPS
- The APM or payment arrangement must require that APM Entities or participants share in the financial risk, or that they are a Medical Home Health Model expanded under section 1115A(c) of the Social Security Act

CMS is currently developing the initial set of Advanced APM determinations to be released no later than January 1, 2017. One example of a current Advanced APM is an accountable care organization set up under the Medicare Shared Savings Program.[1]

Eligible clinicians participating in an Advanced APM who have a certain percentage of their patients or payments through an Advanced APM may become QPs. QPs are excluded from reporting in MIPS and receive a 5% incentive payment each year that the QP is eligible beginning in 2019 through 2024. CMS is currently finalizing the accelerated timeline for making QP determinations, and plans to notify eligible clinicians of their QP status as soon as possible.

Merit-Based Incentive Payment System (MIPS)

MIPS is a new program for Medicare-enrolled practitioners that requires that MIPS-eligible clinicians report data on specific measures each year to set performance standards and incentive payments. It is a combination of three existing programs: the Physician Quality Reporting System, the Physician Value-based Payment Modifier, and the Medicare Electronic Health Record Incentive Program for Eligible Professionals. Even though MACRA and the Rule will sunset these three programs, MIPS will keep the focus on quality, cost, and the use of CEHRT in a way that avoids redundancies.

1 42 U.S.C. § 1395l(z)(3)(C)(ii).

The Rule finalizes the measures, activities, reporting and data submission standards that CMS uses to measure four performance categories. In these performance categories, clinicians must report on a specified number of measures to be eligible to receive the highest possible final scores and fully participate in MIPS.

Performance Category: Quality

Quality measures are selected annually, and CMS publishes the final list each November 1 in the Federal Register. For full participation, clinicians must report on at least six of the measures, including at least one specialty or sub-specialty measure.

Performance Category: Improvement Activities

Improvement activities are activities that respond to broad goals for healthcare delivery, such as care coordination and population management. Improvement activities are weighted to better fit with the different types of patients and practices. For full participation, a clinician must report on at least four medium-weighted activities or two high-weighted activities. Small or rural practices, or practices located in a geographic health professional shortage area, may report on one high-weighted or two medium-weighted activities.

Performance Category: Advancing Care Information

This performance category focuses on the secure exchange of health information and the use of CEHRT to support patient engagement and improved healthcare quality. There are five mandatory reporting measures in this performance category; reporting on all five measures earns the MIPS eligible clinician 50% of its total score. A MIPS-eligible clinician may report on the additional optional measures for a higher score. During the transition years, MIPS-eligible clinicians may receive a bonus for participating in improvement activities for CEHRT and reporting to public health and clinical data registries.

Performance Category: Cost

The final performance category is cost, which does not require any reporting by eligible clinicians. CMS assigns a weight of zero for the transition year for the cost performance category. In later years, however, CMS plans to calculate performance based on certain cost measures and give this feedback to clinicians. CMS plans to use the total per capita costs for all attributed beneficiaries, a Medicare Spending per Beneficiary measure, and finalize 10 episode-based measures in order to quantify this performance category. This performance category's weight will gradually increase from zero in 2017 to 30% in 2021, as required by MACRA.

Scoring and Payment Adjustment

Each performance category score (except for the cost performance category) will be aggregated into a final score and compared against the MIPS performance threshold of three points during the transition period. If the clinician exceeds the MIPS performance threshold, the clinician will receive an upward MIPS payment adjustment. In contrast, if the clinician does not meet the performance threshold, the clinician will be subject to a downward MIPS payment adjustment. CMS estimates that MIPS payment adjustments will be equally distributed between the negative and positive MIPS payment adjustments to ensure budget neutrality in the first payment year. CMS will require higher performance thresholds and longer performance periods for clinicians to avoid a negative MIPS payment adjustment as the program continues.

Transition Period

CMS plans to phase in the reporting provisions in the Rule and provide continuing education and resources to helping clinicians understand the new programs and comply. During the 2017 transition year, CMS will allow clinicians to choose from one of three flexible reporting options to submit data to MIPS and a fourth option to join an Advanced APM. Clinicians may be eligible for upward adjustment payments even if the clinician does not fully participate during this transition year. The options available to clinicians during the transition year are as follows:

- Report to MIPS for a full 90-day period or the full year and become eligible for an additional upward payment adjustment. Exceptional performers, as shown by the practice information they submit, are eligible for upward payment adjustments for each year of the first six years of the program.
- Report to MIPS for 60-90 days, reporting on at least one quality measure, improvement activity, or more than the required measures in the advancing care information performance category, and become eligible for an upward MIPS payment adjustment and avoid a negative payment adjustment.
- Report on at least one measure in the quality or improvement activities performance categories, or report on the required measures of the advancing care information performance category to avoid a negative MIPS payment adjustment. MIPS eligible clinicians that do not report on any measures or activities will receive a full 4% negative payment adjustment.
- Participate in an Advanced APM and become eligible for a 5% bonus incentive payment in 2019 if the clinician receives a sufficient number of their Medicare patients or payments through the Advanced APM.

If the clinician is ready to start to fully participate in MIPS, clinicians use the MIPS reporting guidelines above. CMS recognizes that not all clinicians and practices will be eligible to participate in an Advanced APM or in MIPS because of the size of the practice or the volume of Medicare beneficiaries or payments it receives. CMS does anticipate, however, that small and rural practices will participate in MIPS at similar rates to larger practices, and that 90% of all MIPS-eligible clinicians will receive either a positive or neutral MIPS payment adjustment in the transition year. To this end, CMS will dedicate US$100 million in technical assistance to eligible clinicians in small and rural practices to help them participate and weather the changes in reporting that these new programs will bring.

If you would like to discuss the implications of this Rule for your business, please speak to one of the individuals listed in this publication or your firm contact.

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