The MACRA Final Rule: On Your Mark, Get Set . . . Transition!

written by Dave Halpert | October 28, 2016

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) has (among other things) repealed the Sustainable Growth Rate and incorporated quality measurement into payment, steering away from traditional Fee for Service payments. In other words, revenues are being tied to quality, rather than volume. The Quality Payment Program (QPP) defined within MACRA offers two methods of participation:

- Merit-Based Incentive Payment System (MIPS)
- Advanced Alternate Payment Models (Advanced APMs)

The Final Rule (CMS-5517-FC: "Medicare Program; Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models"), released on October 14, 2016, preserves

CMS's commitment to creating a flexible and streamlined program, aligning prior quality and technology initiatives into one program. There will be financial winners and losers, and most providers, practices and health systems will be impacted. What did change from Proposed to Final Rules—CMS loosened the stringency on some of the specific requirements, enabling providers to ease into the program.

Here's the most important theme: While the Quality Payment Program is a "go," The Final Rule has softened some of the more challenging provisions of the Proposed Rule. Make no mistake—the new program represents a seismic shift in the payment structure, and those eligible who ignore the QPP risk 4 percent penalties. However, in 2017, the first performance year, CMS has made it easier for those who do participate to avoid "negative payment adjustments" (read: cuts) in 2019, the first "payment year."

Who Is Eligible?

There are two factors that determine whether a clinician is eligible:

- Type of Provider: If you are (as defined by CMS) a physician, physician assistant, nurse practitioner, clinical nurse specialist or CRNA, you are included.
- Care Provided: If you bill Medicare more than $30,000 per year, or provide care for more than 100 Medicare patients, you are included (unless 2017 is your first year participating in Medicare). Remember, you don't need to meet both to be eligible; meeting either the volume or fee component is sufficient.

As proposed, MIPS-Eligible Clinicians may submit either as individuals or as Group practices. The rule finalizes NPI/TIN as the identifier for an individual clinician, while the TIN identifies Group Practices. This is the same method used in PQRS. To be counted as a Group Practice, you need to have at least two providers in your TIN, and at least one must be MIPS-eligible. The June 30 registration deadline (the current PQRS deadline) carries over.

What Is Required?

It varies. One thing that didn't change between the Proposed and the Final Rules is that the program was designed to be flexible, and is therefore, complex. In fact, the announcement that eligible providers could "Pick Their Pace," actually makes it more difficult to pinpoint a set of requirements. In general, providers may succeed either in MIPS or through an APM.

MIPS

If participating in MIPS, a provider earns a decile-based (10 levels, not all-or-nothing) composite score based on three categories:

- Quality (Reporting quality measures, the outgrowth of the PQRS)
- Improvement Activities (formerly CPIA, new for MIPS)
- Advancing Care Information (from Meaningful Use, a measurement of whether technology is being used to promote better care).

Notice anything different? The second category, Resource Use, has been removed. This was the next step for the Value Modifier (VM), but the added complexity (scoring based on 41 episodes of care) could not hold up to the volume of critical comments that it was too complex, particularly in the first year of a new program. The 10 percent of the MIPS score that would have come from Resource Use has been reallocated to Quality. It's worth mentioning that Resource Use will be back in the scoring composite for the 2018 performance year, *with triple the weight in 2019.*

As for the remaining categories, there are three ways to avoid penalties:

- Submit a "Test" (one measure or one activity): No penalty
- Submit Partial Data (at least 90 days): No penalty, potential small incentive (depending on the amount of data submitted and performance)
- Submit Full Data (calendar year): No penalty, potential larger incentive (depending on performance)

For the sake of ease, we will be describing the full requirements; this will help you to see what CMS wants to accomplish, and give you the opportunity to evaluate how close you and your practice can get to these targets, as there is a benefit to doing more than the minimum.

MIPS Requirements: Quality (60 percent of the MIPS Composite Score)

Let's start with the biggest change: MIPS is an all-payer program, and that means that your measure denominators are no longer limited to Medicare Part B patients. For some, particularly pediatricians, OB/GYNs and other specialties with traditionally lower Medicare volume, that means that MIPS will be much more germane to your practice than was PQRS. For those in high volume practices, if you have a large commercial mix, expect your measure denominators to grow exponentially.

As proposed, full submission equals at least six measures, including at least one outcome measure (or other high priority measure when no outcome measures is available), with denominators calculated from all patients, across all payers. There is no National Quality Strategy (NQS) Domain requirement.

Two important pieces did NOT make it through the comment period, however: The high “data completeness threshold,” and the “cross-cutting measure requirement.” The reporting requirements only call for a “data completeness threshold” of 50 percent. The 90 percent proposed for Registries and 80 percent proposed for claims-based reporting was walked back to 50 percent, the same level currently required in PQRS. In other words, a measure may be considered “complete” and submitted successfully if a reporting sample of 500 patients from a denominator of 1,000 are included. In a step back from PQRS, a cross-cutting measure is no longer required. Those who were wondering how to collect responses on a cross-cutting measure across all patients can breathe a brief sigh of relief.

There are more than 270 MIPS measures available, not counting those that a QCDR will be able to develop and report on your behalf. In addition to the freedom to select which measures you want to report (unless you report as a group through the CMS Web Interface), you have choices for how you want to report. Groups and individuals may submit via QCDRs, Qualified Registries or EHRs. For those who do not want a partner in this process, you may submit via Part B claims (if an individual) and through the CMS Web Interface if in a registered Group Practice.

MIPS Requirements: Improvement Activities (15 percent of the MIPS Composite Score)

Formerly CPIA, this requirement is similarly structured to what was proposed, but again, the amount required to constitute a “full” submission has decreased. Improvement Activities are still weighted as “high” and “medium,” and 20 points are still assigned to the former, while 10 remain the value for the latter. However, instead of 60 points required to earn the full score in this section, only 40 points are now required. If you have 15 or fewer providers in your practice, you are only required to earn 20 points.

Improvement Activities need to encompass a 90-day period, which reduces burden for practices, and also dovetails with the “partial” submission requirements. Those in MIPS APMs earn half of their points automatically, and those in certified Patient-Centered Medical Homes still earn full credit.

There is no change from the Proposed Rule to the Final Rule when it comes to submission. QCDRs, Qualified Registries and EHRs remain options, and providers will also have the ability to attest, or submit data through administrative claims (if feasible).

MIPS Requirements: Advancing Care Information (25 percent of the MIPS Composite Score)

Meaningful Use may be sunsetting at the end of 2016, but Advancing Care Information serves to remind everyone that Medicare will continue to value Health Information Technology (HIT) in

its quality initiatives, and score it accordingly. In keeping with the transition year theme, the requirements for earning the "base" (50 percent) of this component may be earned by submitting information on five measures formerly included in Meaningful Use, with a bounty of options for providers to fulfill the remaining 50 percent, including Public Health and Clinical Data Registry Reporting.

Noteworthy here is that certain Improvement Activities may serve double-duty with Advancing Care Information categories. Furthermore, eCQMs are not included in this section; all quality measures are scored in the Quality section. Both of these examples illustrate CMS's goal of aligning programs, recognizing that repeating the same tasks represents the same inefficiency that they penalize when calculating cost composites and benchmarks.

Advanced Alternate Payment Models (APMs)

The rule retains the option for providers who choose not to participate in MIPS to be successful via participation in an Advanced Alternate Payment Model (APM). The three standards proposed for qualifying as an Advanced APM are unchanged from the proposal. An APM must meet all of the following:

Report on quality metrics that are "MIPS-comparable."
The majority of participants use Certified EHR Technology (CEHRT).
Participants must bear a "more than nominal" risk standard.

While each component has been retained, CMS has made a concerted effort to encourage APM participation by simplifying and reducing the "nominal risk" standards and offering new options. Rather than requiring APMs to bear a risk of 4 percent of all expected expenditures, CMS is only requiring 3 percent. Depending on the program, that 1 percent difference can represent millions of dollars, and tip the scales for some between jumping in and sitting back. In addition to this benchmark-based standard, CMS has also added a revenue-based standard, wherein risk may be limited to 8 percent of estimated Medicare Part A and B reimbursements for the entities in the APM. To limit confusion, CMS has eliminated "marginal loss rate" (the level at which an APM must pay back excess spending over benchmark) as a component.

Once again, if you're considering participating in an APM, be forewarned that being involved in a program that changes the nature in which payment is earned and delivered does not mean that you are in an Advanced APM. Some may fall between the two tracks (MIPS APMs), while others may not count at all. Only a select few programs have been identified as meeting these standards and counting towards QPP credit:

Comprehensive ESRD Model (two-sided risk arrangements);

Comprehensive Primary Care Plus (CPC+);
Medicare Shared Savings Program (Tracks 2 and 3);
Next Generation ACO Model.

CMS notes that this list is subject to change, and that a final listing will be published before the end of 2016.

What's Next?

Financially, those who do not submit any data in MIPS 2017 will lose 4 percent in 2019. In an ACO, well, it depends on the agreements signed, and the level of excess compared to benchmarks. Each group of participants also has the ability to earn incentive payments. In each case, it depends on your performance compared to peers and/or benchmarks, but MIPS also will factor in the amount of data you submit. As is the case today, results will be publicaly visible. In terms of prestige, pride and future revenues, this should not be ignored.

In future years, expect to see that these eased requirements aren't gifts—*they are loans, and they will need to be paid back, with interest.* The requirements will be strengthened, and to merely fulfill them will not be enough to avoid penalties. Increased flexibility will continue, as practices may link themselves together as "Virtual Groups."

Although not quite the bombshell presented at the proposal stage, the Final Rule clearly marks a new chapter (perhaps a new volume) in the saga of our health care delivery system. All patients are counted, there are mandatory provisions for establishing activities to provide better care, and it's tied together through Health Information Technology.

For those who are ready to take the next step, there is freedom to choose to participate in Advanced Alternative Payment Models. For those in smaller groups who believed that the program would not be feasible, CMS has earmarked $20 million over the next five years to help you succeed. Yes, some of the specifics have been slightly softened between Proposal and Approval, but to see this as a CMS retreat ignores the magnitude of what has changed. We will all be learning this together, and we look forward to bringing you new insights, stories and lessons as we continue to push towards Value-Based Care.

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