MACRA Final Rule Summary

On October 14, 2016, the Centers for Medicare and Medicaid Services (CMS) released its final rule implementing the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), signed into law on April 16, 2015. MACRA repealed the sustainable growth rate (SGR) formula for calculating updates for physician payment and replaced it with a system focused on paying for value, rather than individual services. The final rule establishes the Merit-based Incentive Payment System (MIPS), which replaces the Physician Quality Reporting System (PQRS), the EHR Incentive Program (meaningful use), and the Value-Based Payment Modifier and provides incentives for physicians to participate in alternative payment models (APMs) focusing on coordinated, higher quality care at lower costs.

There will be a 60-day public comment period with comments due on December 19, 2016.

Major Highlights of the MACRA Rule

- In response to comments urging for a delay in implementation, CMS designated 2017 as a transition year for physicians. To avoid a 4 percent penalty in 2019, physicians must report one measure in one of the MIPS categories. Only those who are eligible and choose not to report any data will be assessed the penalty.
- CMS implemented a pick your pace approach in 2017, allowing those who wish to report for either 90 days or the full year to do so and potentially earn a bonus based on the quality information submitted.
- CMS raised the low volume threshold. Clinicians in small practices with less than or equal to $30,000 in Medicare Part B claims or less than or equal to 100 Medicare beneficiaries served will be excluded from participation in MIPS. CMS will allocate $20 million per year for five years to support and train physicians in small practices with 15 or fewer physicians.
- The MIPS resource use component related to cost measures (formerly the value-based payment modifier) will not count towards the MIPS composite score in 2017.
- CMS relaxed the financial criteria for advanced APMs and provided incentives for the testing of new Advanced Alternative Payment Models starting in 2018. Advanced APM bonus payments will be 5 percent of aggregate amounts paid for Medicare Part B professional services

Below is a comprehensive summary of the proposals that can be found in the final rule. For both the MIPS and APM tracks, the reporting year will be 2017 and the performance year during which penalties or bonuses will be assessed will be 2019.

Merit-based Incentive Payment System (MIPS)

2017 Transition Year

Eligible clinicians will have three flexible options to submit data through MIPS and a fourth option to join an Advanced APM in order to become a qualifying APM participant (QP). The three MIPS options are:

Full Reporting: Report all of the required measures for a minimum of a continuous 90-day period or as long as the full year. Those who choose this option will be eligible for a bonus depending on their score.

Partial Reporting: Report MIPS data 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 performance.

Avoid a Penalty: Clinicians can choose to report one measure in the quality performance category; one activity in the improvement activities performance category; or report the required measures of the advancing care information (ACI) performance category and avoid a negative MIPS payment adjustment. All providers who report no data will be assessed the 4 percent penalty in 2019.

MIPS eligible clinicians must submit measures and activities in the Quality, Improvement Activities, and ACI categories. For the transition year, the weight of the Cost category has been lowered to 0, but in future years, when clinicians will be scored on the Cost category, they will not be required to report measures specific to this category, their score will be calculated based on claims data. The deadline for reporting performance data is March 18, 2018. The following chart shows the weight of the MIPS categories in 2017 and the reporting requirements.

2017 Reporting	Quality	Advancing Care Information (ACI)	Improvement Activities	Cost
Weight	60%	25%	15%	0%
Avoid a Penalty	Report one measure **OR**	Report all five base measures **OR**	Report one activity	[redacted]
Full Reporting (90 Days or Full Calendar Year)	Report six quality measures (1 outcome or "high priority" measure) **OR** specialty/subspecialty measure set	90-day reporting period Base score: Report data for the five base measures: 1) Security risk analysis 2) E-prescribing 3) Patients Data Access 4) Summary of care via HIE 5) Requesting or accepting a summary of care. Must report all 5 base measures to receive an ACI score Performance Measures: Choose from 9	Attest completion of minimum of 4 activities for 90 days (2 activities for small & rural practices) Certified PCMHs will receive full credit (Half credit for other APMs) Bonus for any improvement activities that use CEHRT to report to public health or clinical data registries	

		Reporting additional measures can result in a higher score.		
Partial Reporting (90 Days)	More than one measure **OR**	More than the required measures **OR**	More than one activity	

Eligible Clinicians (EC)
At the outset of the program Eligible Clinicians (EC) are defined as Physicians; Physician Assistants; Nurse Practitioners; Clinical Nurse Specialists; and Certified Registered Nurse Anesthetists. Beginning in 2019, other providers may be added, including Physical or Occupational Therapists; Speech Language Pathologists; Audiologists; Nurse Midwives; Clinical Social Workers; Clinical Pathologists; Clinical Psychologists; and Dietitians/Nutritional Professionals.

Low Volume Threshold
CMS revised the low volume threshold in the final rule. Based on historical data, CMS estimates that 32.5% or 380,000 ECs will be excluded initially. Providers with less than or equal to $30,000 in Medicare Part B allowed charges OR less than 101 Medicare beneficiaries seen annually will be excluded.

MIPS Performance Categories and Scoring
The MIPS composite score will be comprised of four components: Quality, Improvement Activities (changed from Clinical Practice Improvement Activities); Advancing Care Information (ACI); and Cost (changed from Resource Use).

Quality Component – 60 percent of total score in 2017

The Quality component will account for 60 percent of a MIPS score in 2017, increased from 50 percent in the proposed rule. Under MIPS, full participation will require reporting on six quality measures, including one outcome measure (or "High Priority" measure if an outcome measure is unavailable), or a specialty/sub-specialty measure set. If the measures set includes fewer than six measures, all measures in the set must be reported. If the measures set includes more than six measures, the provider can choose which of the six measures to report. CMS has developed a new website that allows providers to search all of the measures included in the Quality component - https://qpp.cms.gov/measures/quality

Quality measures will be selected through an annual process and will be published in the *Federal Register* by November 1 of each year. Those reporting in MIPS must report measures for 50 percent of their patients, which is the current requirement under PQRS and lower than what CMS originally proposed. This threshold will increase over time, beginning in 2018. Bonus points will be awarded for reporting outcome and patient experience measures. If an insufficient number of quality measures are available, scores will re-weight advancing care information and improvement activities.

A provider's performance in this category will be measured against baseline benchmarks for the performance year. If there is no benchmark available, the quality score will be determined based on that performance period's data. There will be separate benchmarks for reporting via EHR, qualified clinical data registries (QCDR), qualified registries, Claims, and the group practice reporting option (GPRO). The

rule states that quality scoring is not weighted by the number of each ECs beneficiaries, which CMS is seeking comment on.

Improvement Activities Component – 15 percent of total score in 2017
Reporting for this component requires the attestation on the completion of a minimum of four activities for 90 days. These activities are focused on care coordination, beneficiary engagement, population management, and health equity. Groups with fewer than 15 participants or those in a rural or health professional shortage area will only have to attest for two activities for 90 days. Full credit will be awarded for Patient-Centered Medical Homes (PCMH) and half credit for other alternative payment models.

Advancing Care Information Component – 25 percent of total score in 2017
The ACI component (an update of the meaningful use program), unlike its predecessor, will not be scored on an all-or-nothing basis. The required number of base measures for reporting was reduced from eleven to five. The five base measures include Security Risk Analysis; E-Prescribing; Providing Patient Access; Sending Summaries of Care; and Request/Acceptance of Summary of Care. All other measures would be optional for reporting. Reporting on all five of the required measures would earn the MIPS eligible clinician 50 percent of their score in this category. Reporting on the optional measures would allow a clinician to earn a higher score. For the transition year, CMS will award a bonus score for improvement activities that utilize Certified Electronic Health Record Technology (CEHRT) and for reporting to public health or clinical data registries. The performance period for this component will span any 90-day period, reduced from a full year in the proposed rule.

Providers should be aware that in 2018 reporting under this component will require 2015 Certified Electronic Health Record Technology (CEHRT) and their EHR systems should be evaluated accordingly.

Cost Component – 0 percent of total score in 2017
The weight of the cost component has been lowered to zero for 2017, with an increase to ten percent set for 2018, and thirty percent in 2019. This component replaces the Value-based Payment Modifier. Physicians will not be required to submit data for this component, and the category will be calculated from adjudicated claims by CMS once the cost component takes effect. The performance period will serve as the benchmark, which is national and not regional. In 2017, for informational purposes, CMS will forward to Medicare providers per capita costs (minimum 20 cases) and Medicare spending per beneficiary (minimum 35 cases) as contained in the Quality and Resource Use Reports (QRUR) to review and will provide an understanding of what their performance in this category would look like.

MIPS APMS
For those participating in APMs that do not qualify as an Advanced APM, there will be an option to participate in MIPS. MIPS APMs will not be required to report measures to satisfy the quality component, as the APM measures will be considered sufficient. However, these groups will be required to report improvement activities and ACI measures. For MIPS APMS, improvement activities will be weighted at 25 percent and advancing care information at 75 percent. For MIPS APMs that are ACOs, improvement activities will have a weight of 20 percent and ACI will have a weight of 80 percent.

Advanced Alternative Payment Models

Physicians who provide care to Medicare patients through a recognized advanced APM will be eligible for a 5 percent bonus payment. CMS estimates that 30,000 to 90,000 clinicians could be qualifying APM participants in 2017, and that approximately 25 percent of eligible Medicare clinicians could be in an advanced APM by the second year of the program.

In order to qualify, an advanced APM must be a CMS Innovation Center model; use CEHRT (for 2017, 50 percent of QPs would be required to); base payments for services on quality measures comparable to those in MIPS; be a Medical Home expanded under the Medicare Innovation Center or require participants to "bear more than nominal financial risk for losses." ECs will be notified of their APM status before the end of the performance year. CMS will take three "snapshots" during the performance period: March 31, June 30, and August 31 to identify QPs; CMS had originally proposed only to make this assessment once on December 31 of the reporting year.

Risk Requirements

Participants in advanced APMs place their payments at greater risk than in other APMs. CMS has revised these risk requirements in the final rule, potentially making it easier for APMs to qualify. For 2017 and 2018, risk will be defined in two ways: whichever is lower between a revenue-based standard (8 percent of the average estimated total revenue of participating APM entities) and a benchmark-based standard (3 percent of expected expenditures for which an APM entity is responsible). For payment models based on bundles, expected expenditures will be the target price for the bundle. The proposed marginal risk and medical loss ratio requirements were not finalized.

Also, CMS created a new other payer advanced APM category for APMs under Medicaid or private plans. Risk requirements for these advanced APMs were finalized at 30 percent of expected expenditures with a medical loss ratio (MLR) no greater than 4 percent, and potential risk set at least 4 percent of expected expenditures.

Approved Advanced APM Models

For the 2017 performance year, Track 2 and 3 ACOs; Next Generation ACOs; the comprehensive ESRD care model; the Comprehensive Primary Care Plus demonstration (CPP+); and the Oncology Care Model (two sided risk only) are the approved advanced APMs. In future years, CMS anticipates the following models will qualify: Track 1+ ACOs; Comprehensive Care for Joint Replacement (CJR) Payment Model (CEHRT); Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT); New Voluntary Bundled Payment Model; and Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model) will be added to the list.

The complete list of approved advanced APMs will be published prior to January 1, 2017 and be updated on an ad hoc basis outside of the formal rulemaking process.

New standards by which medical home models may meet the financial risk criteria to be an advanced APM were also established. Those that have been expanded under the Innovation Center's authority will qualify as advanced APMs regardless of whether they meet the financial risk criteria.

Certification of PCMHs was expanded to include comparable specialty practices and those certified by a national, regional, or state program, private payer or other body. PCMHs must meet four of six criteria,

including care coordination across the medical neighborhood. Starting in 2018, a medical home is defined as 50 or fewer ECs in the organization through which the PCMH is owned or operated. This criteria does not apply in 2017. If a PCMH meets general APM risk standards, organizational size is not taken into account. The bonus for PCMH is Part B only. In 2017, risk amounts for Part A and B revenue for PCMHs is 2.5 percent. In 2018 that rises to three percent; four percent in 2019; and five percent in 2020.

Future Advanced APM Thresholds
For 2019-2020, the Qualifying Payment Threshold will be set at 25 percent. From 2021-2022 the threshold will be 50 percent, and from 2023 and beyond, the threshold will be set at 75 percent. During those same time periods, the Qualifying Beneficiary Threshold will be 20 percent; 35 percent; and 50 percent respectively.

Partially Qualifying Thresholds
For 2019-2020, the Partially Qualifying Payment Threshold will be set at 10 percent. From 2021-2022 the threshold will be 25 percent, and from 2023 and beyond, the threshold will be set at 50 percent. The payment threshold was lowered from the proposed rule. During those same time periods, the Partially Qualifying Beneficiary Threshold will be 10 percent; 25 percent; and 35 percent respectively.

Partially qualifying thresholds are for those APMs that do not meet the revenue or patient thresholds for Advanced APMs. Partial qualifiers can choose whether to report under MIPS and those who report are subject to all MIPS requirements and would receive a MIPS payment adjustment. Does not qualify for 5% Advanced APM bonus.

All-Payer Option
For 2017 and 2018, APMs serving Medicare beneficiaries will be the route to APM participation. Starting in 2019, APMs can qualify under the all-payer option which will include Medicare Advantage, Medicaid, and commercial payers. All-payers must also meet the Advanced APM criteria covering quality measures, EHR Use, and financial risk.

Bonus Payments
Advanced APM bonus payments will be 5 percent of aggregate amounts paid for Medicare Part B professional services from the preceding year across all billing TINS associated with the QPs NPI. Bonus payments will be made no later than one year from the end of the incentive payment base period and will be made to the QP's TIN. Multiple TINs will split bonus payments proportionally. $333 million to $571 million in Advanced APM bonus payments are estimated to be awarded in 2019.

Physician-Focused Payment Models (PFPM)
MACRA authorized the Physician-Focused Technical Advisory Committee (PTAC) to advise CMS on the development of physician-focused payment models (PFPMs) that could qualify as APMs or advanced APMs. Review by the PTAC is another option for APM development outside of the Innovation Center. Applications will be submitted on an ongoing basis. PFPMs must include Medicare and may include other payers while ECs must have a core role in implementing payment methodologies. PFPMs must target quality and costs that ECs either provide or can influence. Quality and cost efforts must be expected to improve quality at either no additional cost or a reduced cost. PFPMs should expand APMs

by addressing a payment policy in a novel way or by including entities with currently limited APM participation.

The PTAC will assess whether the PFPM: Incentivizes payment for higher-value care; Improves care delivery through the promotion of better care coordination, the protection of patient safety and the encouragement of patient engagement; and improves the availability of information in order to guide decision-making.