Breaking Down the Medicare Access and CHIP Reauthorization Act (MACRA)

What You Need to Know Now

Background

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) set in motion new provider payment rules that went into effect January 1, 2017 with significant implications for clinicians. MACRA repealed the Medicare Sustainable Growth Rate (SGR) formula and directed the Secretary of Health and Human Services to implement reforms to tie physician payment updates to quality, value, and participation in alternative payment/delivery models.

The law fundamentally changed how Medicare pays clinicians who participate in the program and established two tracks for Medicare reimbursement: the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

Key Dates to Know

January 1, 2017: Beginning of the first performance period under MACRA

January 1, 2019: MACRA implementation date (when Medicare clinician payment will be impacted by MACRA)

While the first year for MACRA implementation is 2019, the performance period began **January 1, 2017.** Thus, performance in 2017 will determine payment adjustments in 2019. Accordingly, providers should begin preparing *now* for MACRA implementation to ease the transition and position themselves for success.

Presented to you by:

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Two New Medicare Part B Advanced Payment Tracks Created Under MACRA (Known as the Quality Payment Program)

Track 1: Merit-Based Incentive Payment System (MIPS)

MIPS rolls existing quality programs (Physician Quality Reporting System, Value-Based Payment Modifier, and Meaningful Use) into one budget-neutral program where providers are scored on quality, cost, improvement activities, and EHR use, and are assigned payment adjustment accordingly.

The Centers for Medicare & Medicaid Services (CMS) expects around 90 percent of providers subject to MACRA to participate in MIPS.

MIPS-Eligible Clinicians

MIPS-eligible clinicians include:

1. Physicians
2. Physician assistants
3. Nurse practitioners (NPs)
4. Clinical nurse specialists
5. Certified registered nurse anesthetists
6. Groups including clinicians who bill under Medicare Part B

MIPS Exclusions

Clinicians are excluded if:

1. They are new to Medicare. In other words, newly enrolled clinicians who have never billed Medicare previously are exempt.
2. They bill less than $30,000 in Medicare allowed charges or furnish services to fewer than 100 Medicare beneficiaries **per year.**
3. They are significantly participating in an Advanced APM (explained on the following page).

MIPS Reporting Requirements Under Four Performance Categories

1) Quality

- Adopted from the Physician Quality Reporting System (PQRS)
- Requires clinicians to report six quality measures to CMS
- Nearly 300 measures to choose from

2) Cost

- Adopted from the Value-Based Payment Modifier (VBPM)
- No reporting requirement
- Assesses clinician cost performance based on Medicare claims data

3) Clinical Practice Improvement Activities

- New performance category for clinicians
- Measures performance by assessing improvement activities focused on care coordination, beneficiary engagement, and patient safety, among others

4) Advancing Care Information (ACI)

- Adopted from the Medicare EHR Incentive Program (Meaningful Use)
- Measures clinicians' certified EHR use
- Applies to all eligible clinicians and no longer requires all-or-nothing measure reporting

Track 2: Advanced Alternative Payment Models (APMs)

This model rewards providers with a five percent annual bonus from 2019–2024 if they have a significant share of their Medicare revenue and/or patients in contracts that include two-sided payment risk. An APM provider will receive a five percent annual bonus from 2019–2024, but retain risk under qualifying payment arrangements (e.g., Next-Generation ACO).

Clinicians who participate in certain Advanced APMs will not be required to participate in MIPS. These eligible clinicians would be exempt from the MIPS payment adjustments and would qualify for a five percent Medicare Part B incentive payment. The MACRA final rule includes a list of current models that qualify under the terms of the rule as Advanced APMs for 2017 as well as Advanced APMs that CMS anticipates will be available in 2018. These include:

For 2017:

- Comprehensive ESRD Care Model (Two-Sided Risk Arrangements)
- Medicare Shared Savings Program—Tracks 2 and 3
- Next Generation ACO Model
- Comprehensive Primary Care Plus (CPC+)
- Oncology Care Model Two-Sided Risk Arrangement

For 2018:

- ACO Track 1+ (a new Advanced APM in 2018 with lower risk levels than currently available to Medicare ACOs)
- New Voluntary Bundled Payment Model
- Advancing Cardiac Care Coordination through Episode Payment Models (Cardiac and Joint Care)

Making the Transition

2017 is a Transition Year: Pick Your Own Reporting Pace

2017 is a transition year from the current federal quality reporting programs (e.g., PQRS, Meaningful Use) to MIPS. The only clinicians who will experience a four percent penalty in 2019 are those who choose not to report any performance data.

Clinicians who submit a minimal amount of data in 2017 will avoid a penalty in 2019.

Specifically, eligible clinicians may report one of the following options to avoid a MIPS penalty:

1. One quality measure, or
2. One improvement activity, or
3. The Advancing Care Information (ACI) base measures

If you choose to do nothing, you'll be automatically hit with a four percent Medicare penalty in 2019.
To maximize the MIPS score in 2017 and potentially earn a bonus, clinicians should take the following actions:

Quality: Capture and report performance data spanning at least 90 consecutive days on up to six quality measures. Performance on each measure is compared to a national benchmark, and eligible professionals may earn up to 10 points per measure. Measures with a low performance rate or that do not satisfy benchmarking or data completeness will still receive a score of '3.'

ACI: Report or attest to meeting four base measures. These measures are "all-or-nothing" and worth 12.5 points toward the 2017 MIPS score. Eligible professionals can also report performance on nine additional measures and earn up to an additional 12.5 points.

Improvement Activities: Report or attest to completing up to four improvement activities for at least 90 consecutive days. Eligible professionals in certain patient-centered medical homes and APMs may qualify automatically for full credit in this category or 15 points towards the 2017 MIPS score.

2018 May Also Be a Transition Year

CMS anticipates that the iterative learning and development period will last longer than the first year of the program, Calendar Year (CY) 2017, as they move toward a steady state; therefore, they envision CY 2018 to also be transitional in nature to provide a ramp-up of the program and of the performance thresholds. CMS anticipates making proposals on the parameters of the second transition year through rulemaking in 2017.

Small Practice Support

The MACRA final rule provided a number of flexibilities designed to assist small practices, including exemptions from new requirements for practices not meeting the low-volume threshold of less than $30,000 in Medicare Part B charges or 100 or fewer Medicare patients. Additional support includes a future "virtual groups" option for individuals and those practitioners with no more than 10 clinicians and $100 million in technical assistance available to MIPS-eligible clinicians in small practices, rural areas, and practices located in geographic health professional shortage areas (HPSAs).

CMS Resources

We have created a resource page on the CAP website with constantly updated information and links to MACRA information, including:

- **Final Rule**
- **Executive Summary**
- **Quality Payment Program Fact Sheet**
- **Quality Payment Program: Key Objectives**
- **Small Practice Fact Sheet**
- **Where to Find Help**
- **Comprehensive List of APMs**
- **How to Design an APM**
- **Learn More About Improvement Activities and APMs**
- **APMs: Medicaid Models and All-Payer Models**

Download all of these resources and a PDF of this white paper, and sign up for MACRA alerts at www.CAPphysicians.com/MACRA

About CAP

The Cooperative of American Physicians, Inc. (CAP) has supported California's best physicians for 40 years with outstanding medical professional liability coverage. CAP provides 12,000 California doctors with medical malpractice protection and comprehensive risk and practice management resources.

This booklet is part of CAP's efforts to support physicians like you with resources that address important back-office issues. We hope you have found it useful.

For more information about CAP or to get a no-obligation quote on medical malpractice protection, please call 800-356-5672 or email MD@CAPphysicians.com.

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